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 Email 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.

Jurisdiction B Transition Update

On 1/4/2016, the Centers for Medicare & Medicaid Services (CMS) awarded the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) to CGS Administrators, LLC located in Nashville, TN. Beginning 7/5/2016, CGS will begin “day one” operations as the new Jurisdiction B DME MAC.

To assist suppliers, CGS has created an implementation website located at http://www.cgsmedicare.com/jb. The website provides regular updates on implementation activities, including scheduled education opportunities. CGS also has opened an Implementation Help Desk, which is available for calls Monday through Friday from 1:00 to 5:00 p.m. central time. Suppliers may call 877-363-8895 for assistance. Suppliers who prefer to ask a question by email can use the “Submit a Question” feature on the implementation website. CGS will respond to your question within 48 hours.

CGS has scheduled a variety of education sessions, including a series of ask-the-contractor teleconferences designed to provide suppliers with the latest news and information regarding implementation activities. As implementation continues, CGS will provide specific actions required of Jurisdiction B suppliers to prepare for the transition. All education, news, and announcements will be listed on the implementation website and will be sent through the NGS listserv/email service.
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APPEALS

Administrative Law Judge Appeal Status Information System

The Office of Medicare Hearings and Appeals (OMHA), which handles Administrative Law Judge (ALJ) hearings for appealed claims, launched a new system that will allow you to track the status of appeals. This system allows you to check the status of appeals you have filed with the OMHA. The system is called the ALJ Appeal Status Information System (AASIS).

It is important to note that your appeal will not appear in the AASIS system until it has been entered into OMHA’s case tracking system (“docketed”) and uploaded to AASIS. Appeal records and data in AASIS are updated weekly, usually on Tuesday. The date of the last update can be found at the bottom or the AASIS inquiry page.

To access AASIS, or to obtain more information regarding the ALJ process you can visit the OMHA website.

COVERAGE, BILLING AND DENIALS

Items Provided on a Recurring Basis and Request for Refill Requirements – Annual Reminder

Joint DME MAC Publication

Posted 1/28/2016

Requirements

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

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

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

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

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

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

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

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

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

Billing Frequencies

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

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

Miscellaneous

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

For additional information, refer to CMS Internet-Only Manual Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.8 and 5.2.9, and the applicable LCDs and the supplier manual.

Related Content

- CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.5 and 5.2.6
- Jurisdiction B Supplier Manual
Reminder – Ordering Physician and CMS-1500 Claim Form

Joint DME MAC Publication

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

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

Completion of Certificates of Medical Necessity

Joint DME MAC Publication

Annual Reminder

Dear Physician:

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

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

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

Printable copies of CMNs and DME Information Forms (DIFs) are available on the CMS website. To find the CMN/DIF you are looking for, enter the name or form number in the “Filter On” field. For instance, if you are searching for the Oxygen CMN, enter the word “oxygen” or “484”.

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

Sincerely,

Stacey V Brennan, M.D.
Executing an Advance Beneficiary Notice of Noncoverage for Drugs, Supplies and/or Accessories

We have seen an increase in claim denials for drugs, supplies, and/or accessories that are provided to Medicare beneficiaries who do not have covered base equipment on file.

As a reminder, when a claim is submitted for durable medical equipment and Medicare denies payment on the basis the equipment is either not medically necessary or noncovered, any drugs, supplies, and/or accessories that are to be used with the base equipment will be denied as not reasonable and necessary.

In order to hold the beneficiary liable for the drugs, supplies, and/or accessories, you must properly execute an Advance Beneficiary Notice of Noncoverage (ABN) prior to delivery of the drugs, supplies and/or accessories. You may refer to Chapter 10 of our supplier manual or refer to our computer-based training course, DME-C-0011, located in Medicare University for instructions about completing the ABN.

Please note, the ABN is valid for the items that are listed for one year from the date the beneficiary or the designee signs the ABN.

Resources

- Jurisdiction B Supplier Manual
- Medicare University

Appropriate Modifiers for Incomplete or Lack of Orders

Suppliers may dispense most durable medical equipment prosthetics, orthotics and supplies (DMEPOS) items based on a dispensing order from the treating physician. However, some DMEPOS items require a written order prior to delivery (WOPD) from the treating physician prior to dispensing the DMEPOS item. Dispensing an item without a valid dispensing order or WOPD will impact the billing to Medicare for reimbursement.

Modifier EY is required to be appended on a claim when a supplier does not have a valid dispensing order or a valid detailed written order (DWO)/WOPD. Reporting this modifier indicates to Medicare that suppliers did not have a valid order. The EY modifier does not assign financial liability.

You will need to properly execute an Advance Beneficiary Notice of Noncoverage (ABN) in order to hold the beneficiary liable for items that will deny as “not medically necessary” when a DWO/WOPD is not received prior to dispensing or does not contain all required components. Properly executing an ABN requires the ABN to be completed, signed and dated by the beneficiary or their designee prior to dispensing the DMEPOS item. If this is completed, modifier GA should be appended on the claim. If an ABN is not properly executed, modifier GZ should be appended on the claim.

In instances where items are “noncovered” or “statutorily excluded/statutory requirement”, an ABN is not required to hold the beneficiary financially liable for the items. As a courtesy to the beneficiary, you may choose to issue the ABN as a voluntary notice. However, when an ABN is issued as a voluntary notice, modifier GA should not be included on the claim line. Modifier GY would be appropriate to use in this situation.

WOPDs

For the following items, there is a statutory requirement for a WOPD:

- Items subject to Section 6407 of the Affordable Care Act
  - Requires the National Provider Identifier (NPI), a date stamp or equivalent, along with other required components of WOPD
• Negative pressure wound therapy (NPWT)
• Power mobility devices
• Wheelchair options and accessories (for power wheelchairs only)
• Pressure reducing support surfaces (Group I, II, III)
• Seat lift mechanisms
• Transcutaneous electrical nerve stimulator (TENS)
• Wheelchair seating

Therefore, for the items listed above, the supplier must have received a WOPD prior to dispensing the item. If you did not receive a WOPD or the WOPD does not contain all required components, the supplier must append modifier EY to the claim to identify a WOPD was not received prior to dispensing. Since this is a statutory requirement, modifier GY would also be appended.

**Dispensing/DWOs**

For all other items, if you do not have a valid dispensing order prior to dispensing the item, you must append modifier EY on the claim. Since this is a statutory requirement, modifier GY would also be appended.

A statutory requirement for a DWO prior to claim submission exists for the following items:

• Oral anticancer drugs
• Oral antiemetic drugs (replacement for intravenous antiemetics)
• Therapeutic shoes for diabetics

Therefore, you must have a DWO prior to submitting the claim to Medicare for the items list above. If you do not have a DWO prior to claim submission, you must append modifier EY on the claim. Since this is a statutory requirement, modifier GY would also be appended.

For all other items not listed above, you are able to dispense with a dispensing order, however, you are required to obtain a valid DWO prior to claim submission. If you bill for an item without obtaining a valid DWO, the item will be denied as not reasonable and necessary. You must append modifier EY to the claim along with modifier GA or modifier GZ to identify a valid DWO was not received. You may only report modifier GA if the ABN was properly executed at the time the DMEPOS item was dispensed. If the ABN was not properly executed, you must report modifier GZ.

Separate claims are required for noncovered/statutorily excluded/statutory requirement items and not medically necessary/reimbursable items.

Refer to Chapter 8 for dispensing orders, DWOs, and WOPDs and Chapter 10 for completion of ABNs of the *Jurisdiction B (JB) Supplier Manual*.

**Related Content**

- *JB Supplier Manual, Chapter 8*
- *JB Supplier Manual, Chapter 10*
- Medical Policy Center

**Unappealable Claims Returned as Unprocessable**

Claims may be returned as unprocessable with American National Standard Institute (ANSI) code 16 or 4 due to missing or invalid information. Some examples of these denials include, but are not limited to: invalid National Provider Identifier (NPI) or missing required information such diagnosis pointer, Healthcare Common Procedure Coding System (HCPCS) code or modifier. We have seen an increase in suppliers submitting appeals for these types of denials. Claims returned as unprocessable do not have
appeal or reopening rights because an initial determination could not be made without all of the required information. When you receive an ANSI 16 or 4 denial, you must make the necessary corrections and resubmit your claim.

If you submit an appeal or a reopening, your request will be sent back via letter advising we are unable to process your request. It is imperative when submitting claims that your claim is complete with all necessary information.

Related Content

- Claim Submission Articles
- Jurisdiction B Supplier Manual, Chapter 12

Coverage Reminder – Transcutaneous Electrical Nerve Stimulators Used For Chronic Low Back Pain

Transcutaneous electrical nerve stimulators (TENS) and related supplies used for chronic low-back pain (CLBP) are only covered when the following criteria are met:

- The beneficiary has one of the Group 1 diagnosis codes listed in the LCD for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802) within the section titled ICD-10 Codes that Support Medical Necessity.
- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in CMS IOM Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 160.27.

TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

Currently, no clinical studies involving TENS for the treatment of CLBP have been approved by CMS. Therefore, claims for TENS units and related supplies used for chronic low-back pain (CLBP) will be denied as not reasonable and necessary.

Coverage requirements for TENS and related supplies used for non-CLBP are outlined in the Coverage Indications, Limitations, and/or Medical Necessity section of LCD for TENS (L33802). The documentation requirements for TENS units are found in the General Information/Documentation Requirements section of the LCD.

For general documentation requirements, refer to the Jurisdiction B (JB) Supplier Manual.

Related Content

- CMS Change Request 7836
- JB Supplier Manual

Fourth Quarter 2015 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 2015 (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 651,402.
<table>
<thead>
<tr>
<th>ANSI Code</th>
<th>Category</th>
<th>Denial Type</th>
<th>October 2015</th>
<th>November 2015</th>
<th>December 2015</th>
<th>4th Quarter Total</th>
<th>% of Denials</th>
</tr>
</thead>
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<tr>
<td>CO-16</td>
<td>Claim/service lacks information which is needed for adjudication.</td>
<td>Return/Reject</td>
<td>21,892</td>
<td>20,320</td>
<td>22,768</td>
<td>64,980</td>
<td>9.96%</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>17,225</td>
<td>14,776</td>
<td>18,319</td>
<td>50,320</td>
<td>7.72%</td>
</tr>
<tr>
<td>CO-18</td>
<td>Duplicate Claim</td>
<td>Duplicate</td>
<td>14,366</td>
<td>13,023</td>
<td>17,351</td>
<td>44,740</td>
<td>6.87%</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>8,799</td>
<td>7,304</td>
<td>7,905</td>
<td>24,008</td>
<td>3.69%</td>
</tr>
<tr>
<td>CO-176</td>
<td>Payment denied because the prescription is not current.</td>
<td>Return/Reject</td>
<td>7,059</td>
<td>6,890</td>
<td>8,847</td>
<td>22,796</td>
<td>3.5%</td>
</tr>
<tr>
<td>CO-A1</td>
<td>Claim/Service denied.</td>
<td>Frequency</td>
<td>7,358</td>
<td>5,481</td>
<td>6,717</td>
<td>19,556</td>
<td>3.0%</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>6,540</td>
<td>5,727</td>
<td>6,312</td>
<td>18,579</td>
<td>2.85%</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>4,669</td>
<td>4,435</td>
<td>4,743</td>
<td>13,847</td>
<td>2.13%</td>
</tr>
<tr>
<td>CO-13</td>
<td>The date of death precedes the date of service.</td>
<td>Return/Reject</td>
<td>2,575</td>
<td>2,366</td>
<td>2,758</td>
<td>7,699</td>
<td>1.18%</td>
</tr>
<tr>
<td>OA-109</td>
<td>Claim is not covered by this payer or contractor.</td>
<td>Return/Reject</td>
<td>2,275</td>
<td>2,366</td>
<td>2,758</td>
<td>6,985</td>
<td>1.03%</td>
</tr>
</tbody>
</table>
1. CO-16 Claim/service lacks information which is needed for adjudication

Claims were submitted to the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (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, you may contact the Provider Contact Center to request additional information regarding the American National Standards Institute (ANSI)-16 rejection. We have received an increase in the volume of claims submitted without a required modifier or with an invalid modifier. You 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, you 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 our website by selecting the Policy tab, then click the Medical Policy Center link. 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-4: The procedure code is inconsistent with the modifier used, or a required modifier is missing

For a complete listing of the Healthcare Common Procedure Coding System (HCPCS) modifiers, please consult the Jurisdiction B (JB) Supplier Manual, Chapter 14 “Level II HCPCS Codes and HCPCS Modifiers.” Additionally, specific instructions regarding modifier usage is located in the JB Supplier Manual, Chapter 15, “DMEPOS Payment Categories.” The LCDs 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 our website.

You may also utilize the DME Coding System (DMECS) Info, 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. To search for HCPCS and modifier coding or to find out more about the DMECS, please visit the Pricing, Data Analysis, and Coding Contractor’s website.

3. CO-18: Duplicate claims

We receive 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 HCPCS code.

You 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. You 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.

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

You should evaluate the patient’s history during the intake process to determine if the same or similar equipment was previously obtained. You may utilize CSI, NGSConnex or the IVR system at 877-299-7900 to determine if the beneficiary’s record indicates they 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 you were unaware of the previous purchase, you should refund
the beneficiary (if applicable). You may choose to exercise your right to request a redetermination. Redetermination requests may be submitted to the following address:

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

You may also fax redetermination requests. You 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 our secure Internet portal, NGSConnex. Access to NGSConnex only requires users to have the Internet and an email address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.

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

We encourage you to review the medical policies, referred to as 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, you should ensure that all sections of the CMN are completed prior to submitting the claim to the DME MAC. You 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 our website.

However, if a claim denies because the patient has previously received same/similar equipment, and you were unaware of the previous purchase, you 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

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

6. CO-A1: Claim/service denied

Our records indicate that the billing exceeds the rental months for oxygen. You may utilize NGSConnex or the IVR unit at 877-299-7900 to determine if the beneficiary’s record indicates there are 36 rentals on file for oxygen.

7. OA-24: Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

Our 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. You must submit your claim to the appropriate insurance carrier for the specific HMO in which the beneficiary is enrolled. We encourage
you to utilize the **IVR system** or **NGSConnex** 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, you 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. You may access the IVR system by dialing 877-299-7900. For additional information regarding the IVR unit, refer to the Jurisdiction B DME MAC IVR User Guide located on our website.

Online eligibility is available through the free, online application **NGSConnex**. NGSConnex offers you superior search capabilities that will help make it fast and easy for you to find the information you seek without having to place calls to our Provider Contact Center.

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

We encourage you 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, you should ensure that all sections of the CMN are completed prior to claim submission to the DME MAC. You 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 our website.

9. **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. You should contact the beneficiary to whom they are providing service, to determine whether the beneficiary is still using the supplier's equipment. We also recommended that you check your patients' Health Insurance Claim card and Medicare records for valid coverage dates and for correct patient information prior to claim submission.

10. **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 NGSConnex 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, you are 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, you may resubmit your claim to the DME MAC for payment. Prior to resubmission, NGSConnex and/or the IVR should be checked again to confirm the correction has been made to the discharge dates.

### ELECTRONIC DATA INTERCHANGE

**Electronic Signature Is Here For CEDI Enrollment Forms**

On 1/29/2016, the Common Electronic Data Interchange (CEDI) implemented electronic signatures for online CEDI enrollment forms. All CEDI enrollment forms are completed and submitted online through the CEDI website. With the implementation of electronic signature, CEDI customers will no longer be required to print, sign and fax the forms before they can be processed. CEDI will be able to begin processing your enrollment request once it is submitted online.
An instruction guide for the electronic signature process is available on the Frequently Asked Questions page of the CEDI website.

If you completed a CEDI enrollment form online prior to the implementation of electronic signature, you must fax the signed form within ten days of the online submission for CEDI to process your request. You will not need to complete any new enrollment forms for requests that have already been submitted.

CEDI will continue to verify the information on the forms as we do today. If a request is rejected, you will be notified by email and will need to complete a new form online, correcting the errors.

The following are the top reasons for rejected CEDI enrollment forms:

- Signee is not authorized to sign on behalf of the supplier
- Trading partner/submitter identification (ID) is missing or invalid
- Electronic remittance advice (ERA) enrollment form is required in order to process your request
- Third party supplier authorization form is required in order to process your request
- ERA form received but 835 transaction is not selected on the supplier authorization form or submitter action request form
- ERA enrollment agreement not on file for this provider
- Requested Transactions are not setup for the trading partner ID

Please allow up to ten business days to complete your request(s).

The CEDI website offers an Enrollment Status Tool to check the status of the CEDI enrollment forms you have submitted.

If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@anthem.com or at 866-311-9184

**FEE SCHEDULE, PRICING AND OVERPAYMENTS**

**2016 Medicare Fee Schedule Amounts and Rural ZIP Code File**

On 11/23/2015, the Centers for Medicare & Medicaid Services (CMS) released the 2016 Medicare durable medical equipment prosthetics, orthotics and supplies (DMEPOS) fee schedule amounts. The DMEPOS and parenteral and enteral nutrition (PEN) public use files contain fee schedules for certain items that were adjusted based on information from the Medicare DMEPOS Competitive Bidding Program. CMS identified errors in the fee schedule amounts for some items and has therefore released revised fee schedule files on 12/8/2015.

- 2016 DMEPOS Fee Schedule – Excel File, Revised January 2016
- 2016 PEN Fee Schedule – Excel File, Revised January 2016
- 2016 DME Rural ZIP Codes – Excel File, Revised January

The DMEPOS and PEN fee schedule files contain columns identified with the state abbreviation code and an abbreviation of R to indicate rural and NR to indicate nonrural. If the beneficiary’s permanent address on file with the Social Security Administration is in a rural ZIP Code included in the DME Rural ZIP Code file and the Healthcare Common Procedure Coding System (HCPCS) code for the item provided is included in the Competitive Bidding Program you will be paid the amount listed in the column for the state where the beneficiary resides and the abbreviation R.
Scenario #1:
In the example below, a standard manual wheelchair (K0001), which is included in the Competitive Bidding Program, is being provided to a beneficiary that resides in Illinois.

How to Determine the Allowed Amount:
1. Determine if the beneficiary’s ZIP Code is included in the DME Rural ZIP Code file
2. If the beneficiary’s ZIP Code is included in the DME Rural ZIP file you will be paid the amount listed in the column identified with IL (R) $44.05.
3. If the beneficiary’s ZIP Code is not included in the DME Rural ZIP file, but the beneficiary lives in an area in Illinois that falls outside of a Competitive Bid area you will be paid the amount listed in the column identified IL (NR) $42.13

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Mod</th>
<th>Mod 2</th>
<th>JURIS</th>
<th>CATG</th>
<th>Ceiling</th>
<th>Floor</th>
<th>IL (NR)</th>
<th>IL (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0001</td>
<td>RR</td>
<td>D</td>
<td>CR</td>
<td>0.00</td>
<td>0.00</td>
<td>42.13</td>
<td>44.05</td>
<td></td>
</tr>
</tbody>
</table>

You will notice when reviewing the DMEPOS and PEN fee schedule files that certain items will only have an amount listed in the nonrural column. Those items are not included in the Competitive Bidding Program, and all suppliers will be paid the fee schedule amount listed in the nonrural column.

Scenario #2:
In the example below, an ostomy pouch (A4413), which is not included in the Competitive Bidding Program, is being provided to a beneficiary that resides in Illinois.

How to Determine the Allowed Amount:
1. Determine the state where the beneficiary resides.
2. Locate the column that includes the state abbreviation.
3. You will be paid the fee schedule amount indicated in the column identified IL (NR) $6.09 per unit regardless of where the beneficiary resides in Illinois.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Mod</th>
<th>Mod 2</th>
<th>JURIS</th>
<th>CATG</th>
<th>Ceiling</th>
<th>Floor</th>
<th>IL (NR)</th>
<th>IL (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4413</td>
<td></td>
<td></td>
<td>OS</td>
<td>6.09</td>
<td>5.18</td>
<td>6.09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You may also notice when reviewing the DMEPOS and PEN fee schedule files that some items will not have an amount listed in either the nonrural or rural column. Those items are not included in the Competitive Bidding Program, and do not have an established fee schedule. The item could either be statutorily noncovered by Medicare or priced using a different pricing methodology.

Note: If a beneficiary resides in a competitive bidding area and the item provided is competitively bid you will be paid at the single payment amount established for the item in the competitive bidding area. The Single Payment Amount charts are located on the CBIC website.
MEDICAL POLICY

Local Coverage Determination and Policy Article Revisions Summary for 12/3/2015

Outlined below are the principal changes to a DME MAC LCD and a PA that have been revised and posted. The policy included is wheelchair seating. Please review the entire LCD and related PA for complete information.

Wheelchair Seating

LCD

Revision Effective Date: 10/01/2015
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY
Added: ICD-10 codes for Stage 1 Pressure Ulcers

DOCUMENTATION REQUIREMENTS
Removed: Start date verbiage from Prescription Requirements
Added: Standard documentation language for dates on orders

Policy Article

Revision Effective Date: 10/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements

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.

Local Coverage Determination and Policy Article Revisions Summary for 12/17/2015

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

Nebulizers

LCD

Revision Effective Date: 1/1/2016
COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Deleted: HCPCS Code A7011 from Accessories tables
HCPCS CODES:
Deleted: HCPCS Code A7011
Added: HCPCS Code J7999
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Group 5 Codes:
Deleted: Code A7011 from the List of HCPCS codes
Group 7 Codes:
Added: ICD-10 Code E84.0 to Group 7 for J7608
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)
MISCELLANEOUS:
Deleted: Duplicative information about what is required on orders
Updated: HCPCS Code Q9977 cross-walked to J7999
Added: Standard product identification requirements for NOC codes

Policy Article
Revision Effective Date: 1/1/2016
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)
CODING GUIDELINES:
Updated: HCPCS Code Q9977 cross-walked to J7999

Pneumatic Compression Devices

LCD
Revision Effective Date: 12/1/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Trial requirements to reference “no significant improvement” rather than “no further improvement”
for lymphedema, CVI, and for lymphedema extending on to the chest, trunk and/or abdomen
Removed: Word “Any” from trial requirements for lymphedema of the chest, trunk and/or abdomen
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements
(Effective 11/5/2015)

Policy Article
Revision Effective Date: 12/1/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements (Effective 11/5/2015)

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

MISCELLANEOUS SUPPLIER INFORMATION

Notice of New Interest Rates for Medicare Overpayments and Underpayments – Change Request 9532
Effective 1/19/2016, the new interest rate for Medicare overpayments and underpayments is 9.75 percent.

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.
### Microsoft Ends Support for Older Versions of Internet Explorer

As of 1/12/2016, Microsoft is no longer providing security updates, compatibility fixes or technical support for older versions of Internet Explorer. These versions include Internet Explorer 7, 8, 9 and 10. Microsoft encourages users to immediately upgrade to Internet Explorer 11 which it will continue to support.

According to our data, **34% of visitors to NGSMedicare.com are using an older version of Internet Explorer**. We recommend, as does Microsoft, to upgrade to Internet Explorer 11 if you are using an older version of Internet Explorer.

To upgrade to Internet Explorer 11, visit the [Microsoft Browsers page](#).

For more information on Microsoft ending support of Internet Explorer, visit the [Microsoft website](#).

### Comprehensive Error Rate Testing High-Error Audit – Third Quarter 2015 Widespread Prepayment Review Update

Jurisdiction B continues to conduct a prepayment medical review of Comprehensive Error Rate Testing (CERT) high-error audit claims.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 3,352 claims. A total of 1,396 claims were allowed and 1,956 claims were denied, resulting in a claim error rate of 58.35 percent. A total of 214 claims denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4Q2014</td>
<td>5,893</td>
<td>56.46%</td>
</tr>
<tr>
<td>1Q2015</td>
<td>5,400</td>
<td>61.41%</td>
</tr>
<tr>
<td>2Q2015</td>
<td>4,546</td>
<td>64.58%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>3,352</td>
<td>58.35%</td>
</tr>
</tbody>
</table>

Data collected during the third quarter identified the top denial reasons as:

**Nutrition Claims**
- The refill request documentation was not received.
- Beneficiary’s medical records did not demonstrate that the item was reasonable and necessary prior to the initial order.
• Medical necessity for special enteral formulas not shown.
• No documentation to support the beneficiary had a covered situation from policy article A47126, prosthetic benefit requirements section to allow coverage for parenteral nutrition.
• The date the beneficiary received the durable medical equipment prosthetics, orthotics and supplies (DMEPOS) supply delivered directly by the supplier did not match the date of service on the claim.

Prosthetic and Orthotic Claims
• The proof of delivery record did not include sufficiently detailed description to identify the item(s) delivered.
• No statement or reason in physicians order and or medical documentation for items to be replaced.
• The medical records submitted did not clearly demonstrate the beneficiary’s past history (including prior prosthetic use if applicable).
• No medical records were submitted.
• Healthcare Common Procedure Coding System (HCPCS) code(s) is not payable.

Power Mobility Device Claims
• The specialty evaluation did not provide detailed information explaining why each specific option or accessory is needed to address the beneficiary’s mobility limitation (add the specific option or accessory if needed).
• The documentation does not support the physical or functional deficits to justify the medical necessity for the option/accessory.
• The payment for this HCPCS code is included in the allowance of another submitted HCPCS code.
• The service is not separately payable with the wheelchair base code.
• The detailed product description contains a power wheelchair base code that cannot accommodate the accessories listed.

Drug Claims
• No medical records were submitted.
• The detailed written order did not include a physician signature that complied with the Centers for Medicare & Medicaid Services (CMS) signature requirements outlined in CMS Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, 3.3.2.4.and signature date.
• The refill request was not obtained and documented before shipment.
• The shipping date did not match the date of service on the claim for a shipping service or mail order by the supplier.
• The detailed written order did not include the quantity to be dispensed.
• The medical documentation contains a missing signature.

Negative Pressure Wound Therapy Pump Claims
• Supplier-produced records, even if signed by the ordering physician, and attestation letters are deemed not to be part of a medical record for Medicare payment purposes.
• No required documentation to justify the medical need of the item billed.
• No physician records were received.
• No evidence of a licensed medical professional on at least a monthly basis, documented changes in the ulcer’s dimensions and characteristics.
• No evidence of a licensed medical professional directly assessed the wound(s) being treated with the negative pressure wound therapy pump.

Surgical Dressing Claims
• Wound debridement was not seen in the document.
• Order did not specify quantity to be used at one time.
• Documentation does not support dressing size billed.
• Documentation does not support monthly wound evaluation.
• No medical records were submitted.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on these HCPCS codes through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states the following: “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

You can quickly obtain additional details about the reason for a complex or noncomplex medical review denial view by using the Medical Review Denial Tool, which is available on the our website. To use the tool, enter the 14-digit claim control number (CCN) from your remittance advice, in the CCN form field and select Submit. Select Reset to enter information for a new CCN. The Medical Review Denial Tool is available on our website under Supplier Resources, then Calculations & Tools.

To help avoid these sorts of errors and to help ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.

Related Content
• Calculators & Tools
• CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15
• Jurisdiction B Supplier Manual
• Medical Policy Center
• Medical Review Focus Areas
• Medical Review Denial Tool
• Medicare University Course List
• Policy Education Topics

Complete Supplier Manual Chapters Now Available

We heard you....you want easy and fast. With that in mind, we created "complete" supplier manual chapters on NGSMedicare.com making it easier to quickly access the information you need. You can find the full supplier manual chapters at the bottom of each chapter dropdown menu on our Supplier Manual page. The new comprehensive chapters are now printable.

We hope you are excited about this new feature and would love to hear your feedback. Check it out and click "Yes" the next time the ForeSee survey pops up and tell us how you like it. Your feedback drives change.

Fourth Quarter 2015 Supplier Telephone Inquiries

We have included a review of the top telephone inquiries for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the fourth quarter of calendar year 2015 (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 Provider Contact Center received 42,231 telephone inquiries for the fourth quarter of 2015. 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 – Frequency/Dollar Amount (7,229)

You should refer to each individual local medical policy to verify coverage criteria for an item and/or service. When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, you must obtain information supporting the medical necessity for the higher utilization. This information must be retained in your file and be available to the Jurisdiction B DME MAC upon request. Medical policies can be accessed from the Medical Policy Center section of our website.

For medical necessity denials, suppliers are given the option to request a redetermination by submitting supporting documentation along with the request. You may file your redetermination 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 our website.

2. Claim Denials – Medical Necessity (3,955)

You are encouraged to consult the local coverage determinations (LCD) and policy articles for individual medical policy coverage criteria, which are located on our website. For medical necessity denials, you are given the option to submit the claim along with supporting documentation as an appeal request. You may submit redetermination requests to the following address:

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

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

You 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 email address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.

3. Claim Denials – Contractual Obligation Not Met (3,567)

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. You should reference the Jurisdiction B (JB) Supplier Manual, Chapter 12 for instructions on claim completion as well as claim filing time limits and other helpful information.
4. Coding – Modifiers (2,750)

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 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 JB Supplier Manual, Chapter 14. Special coverage guidelines are published in each individual medical policy. The local coverage determinations (LCDs) 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 our website.

You 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.

5. Claim Status – Payment/Explanation/Calculation (2,257)

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 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.

6. Claim Denials – Claim Overlap (1,893)

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. You 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 one 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, you may contact the Provider Contact Center for assistance at 866-590-6727. You 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.

7. Claim Denials – Statutory Exclusion (1,822)

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.”

You are encouraged to review the JB 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 our website. In addition, the LCDs and policy articles both provide specific instructions when an item or service indicated in the LCD and policy article are deemed to be excluded from coverage.

8. Policy Coverage Rules – Pre Authorization (1,768)

This denial is given when a claim is submitted with either a missing, incomplete or invalid unique tracking number (UTN) for a power mobility device (PMD) prior authorization request (PAR). If you receive an affirmed decision on a PMD PAR, you are required to submit the UTN on the claim. The UTN is located on the decision letter sent by National Government Services. For paper claims, the UTN is reported in Item 23 of the CMS-1500 paper claim form. For electronic claims, the UTN is submitted at either loop 2300 REF02 (REF01=G1) or loop 2400 REF02 (REF01=G1). For electronic submitters, if you are unsure where these loops are, please contact your software vendor.

As a reminder, reporting of a UTN is not necessary for accessories for a PMD. National Government Services, the Jurisdiction B DME MAC processes PMD PARs for beneficiaries residing in Illinois, Indiana, Kentucky, Michigan and Ohio.

9. Claim Status – Not on file (1,543)

Verify your claim status by utilizing the IVR system, NGSConnex or CSI. Verify your claim was submitted to the correct DME MAC. More information regarding claim filing jurisdiction can be found in the JB 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.

10. Claim Denials – Certification Requirements (1,456)

This denial is given when a claim is submitted with an outdated prescription, Certificate of Medical Necessity (CMN) or DME Information Form (DIF). You should utilize CSI, NGSConnex or the IVR system 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. You 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.

Fourth Quarter 2015 Supplier Written Inquiries

We have 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 2015 (October–December). Our Written Correspondence Unit received 5,638 written inquires 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 (1,230)

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 (JB) Supplier Manual, Chapter 14. Additionally, specific instructions regarding modifier usage is located in the JB 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 our website.

You 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 Centers for Medicare & Medicaid Services (CMS) national fee schedules.

2. Claim Denials – Contractual Obligation Not Met (552)

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. You should reference the JB Supplier Manual, Chapter 12 for instructions on claim completion as well as claim filing time limits and other helpful information.

3. Claim Status – Payment Explanation/Calculation (482)

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 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. General Information – Issue Not Identified/Incomplete Information (401)

You 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:
5. Claim Denials – Medical Necessity (383)

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

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

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

You 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 email address. There are no costs associated with using this application. For additional information regarding NGSConnex, you should login to the NGSConnex application.

6. Claim Denials – Frequency/Dollar Amount Limitation (352)

You should refer to each individual local medical policy to verify coverage criteria for an item and/or service. When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, you must obtain information supporting the medical necessity for the higher utilization. This information must be retained in your file and be available to the Jurisdiction B DME MAC upon request. Medical policies can be accessed from the Medical Policy Center section of our website.

For medical necessity denials, you are given the option to request a redetermination by submitting supporting documentation along with the request. You may file your redetermination 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 our website.

7. Claim Denials – Certification Requirements (301)

This denial is given when a claim is submitted with an outdated prescription, Certificate of Medical Necessity (CMN) or DME Information Form (DIF). You should utilize CSI, NGSConnex or the IVR system 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 system will provide the previous supplier’s name and telephone number. You 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.
8. Claim Denials – Duplicate (228)

We receive 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.

You 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. You 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 our website.

For additional information regarding steps to take to avoid duplicate denials, please review the article titled “How To Prevent Duplicate Claim Denials Article” on our website.

9. Claim Denials – Competitive Bidding Program (176)

The DMEPOS Competitive Bidding Program is designed to improve the effectiveness of Medicare’s DMEPOS payments, reduce beneficiary out-of-pocket costs, and save the Medicare Program money while ensuring beneficiary access to quality DMEPOS items and services.

This denial is due to issues related to DMEPOS items denying when a noncontract supplier is billing for repair/service/replacement, misuse or missing modifiers. You should reference the JB Supplier Manual, Chapter 3 and Chapter 14 regarding the competitive bidding program and appropriate modifiers. Additional information can also be obtained at the Competitive Bidding Implementation Contractor’s (CBICs) website regarding the correct round for the National Competitive Bidding Program and related educational fact sheets.

10. Claim Denial – Statutory Exclusion (141)

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 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 IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 “General Exclusions from Coverage”.

Suppliers are encouraged to review the JB 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 our website. In addition, the local coverage determination and policy articles both provide specific instructions when an item or service indicated in the LCD and policy article are deemed to be excluded from coverage.
Self-Service

Are You Taking Advantage of The Personalized Experience On NGSMedicare.com?

Since we launched our Personalized Experience Home page last August, we have had thousands of suppliers sign up and create a Personalized Experience account. Week after week, suppliers have told us how much time they save and how easy it is to get to the local coverage determinations (LCDs) and Policies that matter most to their business. And while, most of our suppliers have signed up and are enjoying the benefits of logging into the Personalized Experience, we still see that there are some who are not yet.

If you haven’t signed up and created your Personalized Experience account yet, it’s a simple process that takes a little time but will save you lots. Simply click on the National Government Services logo in the top left-hand corner of our site to access the Welcome page where you can click on the “Create Account” link to create your account and access the Personalized Experience Home page.

If you have signed up, you can also log in to your Personalized Experience account by clicking on the NGS logo to access the Welcome page and login with your username and password. By logging in, you will then see your Personalized Experience Home page that is customized for you. If you don’t log in, the Home page will look like it has in the past with no quick links to your favorite policies, LCDs, supplier manual pages and news articles.

From the Personalized Experience Home page, you can find the LCDs and policy articles based on your Specialties under the My Policies Tab on the left side. Simply click the My Policies Tab and then click on the LCD or policy article you want to see. That’s it. It’s never been quicker and easier to access your top LCDs and policy articles than with the new Personalized Experience Home Page.

Saving you even more time, you can add your favorite and most used Calculators and Tools to the right side of your Personalized Experience Home page. Rather than having to click on the Calculators & Tools link and then clicking on the tool you need, you now can use your favorite calculators and tools right from the Personalized Experience Home page without clicking a link or accessing another page.

So what are you waiting for? Join the thousands of other suppliers who have already been saving time and enjoying the convenience of accessing the most popular parts of the NGSMedicare.com site from one simple yet great page, the Personalized Experience Home page.

NGSConnex Same or Similar/CMN Detail for DMEPOS Items

Did you know that you may utilize National Government Services (NGS) Connex to search for same or similar items on file and view Certificate of Medical Necessity (CMN) detail (when applicable) for a beneficiary?

For durable medical equipment (DME), items classified as a capped rental item, frequent and substantially serviced item, inexpensive and routinely purchased item, or items requiring a CMN or DIF, the system will first search the Jurisdiction B local records. If no same or similar codes are found in the Jurisdiction B local records for the DME Healthcare Common Procedure Coding System (HCPCS) code entered, the system will then search the Common Working File (CWF).

Suppliers may also use NGSConnex to search for same or similar A, L or V codes on file for the beneficiary. This feature allows suppliers of orthotics, prosthetics and supplies to obtain same or similar information for the majority of the HCPCS codes that begin with letters A, L or V. For A, L, and V codes,
NGSConnex is only able to search the Jurisdiction B local records. Suppliers will still need to speak with a live customer care representative to obtain same and similar information for HCPCS codes: A4218, A7018, L0641–L0643, L0648–L0651, L1866, L1848, L8039 and L8048–L8049.

To use NGSConnex to search for same or similar items on file for a beneficiary, log into the NGSConnex online web application.

- Click the **My Claims Tab**
  - If there is more than one provider account, click the arrow to the left of the provider account, then click the Select button for that account
- Select **Same or Similar** in the **Claim Type** drop down
- Enter the **Beneficiary Medicare Number**, **Beneficiary Last Name**, **Beneficiary First Name** (at least the first initial), **Beneficiary Date of Birth** (MMDDYYYY or MM/DD/YYYY format), and **HCPCS code** you wish to search
  - You may also enter a date of service. If a date of service is entered, information will only be returned pertaining to the date of service entered. If a date of service is not entered, NGSConnex will display a list of processed claims:
    - Most recently processed claims within five years for DME HCPCS codes
    - Most recently processed claims within the year for A HCPCS codes
    - Most recently processed claims within five years for L HCPCS codes
    - Most recently processed claims within five years for V HCPCS codes
- Select the **Load** button

 Suppliers should take all necessary actions to determine if a beneficiary has a same or similar item on file prior to dispensing the item that is ordered. Using NGSConnex to obtain same/similar claim information saves you time by placing this valuable information at your fingertips.

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**Drugs/Infusion/Parenteral and Enteral Nutrition and Infusion**

**PARENTERAL AND ENTERAL NUTRITION AND INFUSION**

**Coverage and Correct Coding of Duopa™ (Levodopa-Carbidopa Enteral Suspension) – Revised**

*Joint DME MAC Publication*

*Revised 1/7/2016
Posted 2/20/2015*

*This is a revision to a previous version published 2/20/2015 and adds the new HCPCS code for Duopa™.*

On 1/9/2015, Duopa™ (AbbVie) was approved by the Food and Drug Administration (FDA). Duopa™ is an enteral-suspension combination of levodopa and carbidopa, and is indicated for the treatment of Parkinson’s disease (PD). Duopa™ is administered as a continuous 16-hour infusion into the jejunum through a percutaneous endoscopic gastrostomy-jejunal tube (PEG-J), using a CADD®-Legacy 1400 portable infusion pump.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Duopa™ and determined that it is eligible for inclusion in the DME external infusion pump LCD. Refer to the external infusion pump local coverage determination (LCD) and policy article for specific coverage requirements.
You are reminded that when submitting claims for items coded J7799, you must include the following information on each claim:

- Name of drug
- Dosage strength
- Amount dispensed (e.g., total mg)
- Administration instructions

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

Claims for Duopa® for dates of service on or after 1/9/2015 through 12/31/2015 must be submitted using the HCPCS code J7799 (not otherwise classified [NOC] drugs, other than inhalation drugs, administered through DME).

Claims for Duopa® for dates of service on or after 1/1/2016 must be submitted using the HCPCS code J7340 (carbidopa 5 mg/levodopa 20 mg enteral suspension).

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

Refer to the, the external infusion pump LCD and related policy article for additional coverage, coding and documentation requirements.

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

**Related Content**

- DME PDAC Contact Form
- External Infusion Pumps - Policy Article (A47226)
- LCD for External Infusion Pumps (L27215)

**Coverage and Correct Coding of YONDELIS®**

**Joint DME MAC Publication**

On 10/23/2015 the Food and Drug Administration (FDA) gave accelerated approval to YONDELIS® (trabectedin), a chemotherapy treatment for specific soft tissue sarcomas (STS) – liposarcoma and leiomyosarcoma – that cannot be removed by surgery (unresectable) or is advanced (metastatic). This treatment is approved for patients who previously received chemotherapy that contained anthracycline.

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

Claims to the DME MACs for YONDELIS® whose administration is initiated in a provider’s office will be rejected as wrong jurisdiction. Please consult with the appropriate A/B MAC for potential reimbursement under part B of the Medicare Program.
Please refer to the external infusion pump local coverage determination (LCD) and related policy article for additional coverage, coding and documentation requirements.

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

**Related Content**
- DME PDAC Contact Form
- External Infusion Pumps - Policy Article - Effective December 2015 (A52507)
- LCD for External Infusion Pumps (L33794)

**Coverage and Correct Coding of Blincyto™– Revised**

_Joint DME MAC Publication_

_Revised 1/7/2016_

*This is a revision to a previous version published 2/20/2015 and adds the new Healthcare Common Procedure Coding System (HCPCS) code for blinatumomab.*

On 12/3/2014, the Food and Drug Administration (FDA) gave accelerated approval for Blinatumomab (Blincyto™) for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Blincyto™ is a bispecific CD19-directed CD3 T-cell engager that activates endogenous T cells when bound to the CD19-expressing target cell (B cells). Activation of the immune system results in release of inflammatory cytokines. The FDA-approved schedule is for six-week cycles, for a total five cycles.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Blincyto™ and determined that it is eligible for inclusion in the durable medical equipment (DME) external infusion pump local coverage determination (LCD).

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

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

- Name of drug
- Dosage strength
- Amount dispensed (e.g., total mg)
- Administration instructions

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

Claims for Blincyto™ for dates of service on or after 12/3/2014 through 12/31/2015, must be submitted using the HCPCS code J7799 (not otherwise classified [NOC] drugs, other than inhalation drugs, administered through DME).
Claims for Blincyto™ for dates of service on or after 1/1/2016 must be submitted using HCPCS code J9039 (Injection, blinatumomab, 1 microgram).

Please refer to the external infusion pump LCD and related policy article for additional coverage, coding and documentation requirements.

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

Related Content
- DME PDAC Contact Form
- External Infusion Pumps - Policy Article (A47226)
- LCD for External Infusion Pumps (L27215)

Correct Coding – NOC Codes for Enteral (B9998) and Parenteral (B9999) Nutrition

Joint DME MAC Publication

Published 2/11/2016

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

- B9998 – NOC for enteral supplies
- B9999 – NOC for parenteral supplies

Correct coding requires the use of a specific Healthcare Common Procedure Coding System (HCPCS) code for an item when a specific code exists. Use of a NOC code in place of a specific code represents incorrect coding.

Enteral Nutrition

The analysis of B9998 reviewed 909 claim lines finding that:

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

These claim lines are incorrectly coded.

The enteral nutrition related policy article Coding Guidelines describe the requirements applicable to supplies used with enteral nutrition. The applicable supply allowance codes are:

- B4034 – Enteral feeding supply kit; syringe fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
- B4035 – Enteral feeding supply kit; pump fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
- B4036 – Enteral feeding supply kit; gravity fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
From the Coding Guidelines:

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

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

Use of a NOC code to bill for an enteral pump is incorrect coding. B9000 (Enteral nutrition infusion pump – without alarm) and B9002 (Enteral nutrition infusion pump – with alarm) are separately billable, specific HCPCS codes to be used for these items.

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

**Parenteral Nutrition**

The analysis of B9999 reviewed 1196 claim lines finding that:

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

These claim lines are incorrectly coded.

The applicable supply allowance codes for parenteral nutrition are:

- B4220 – Parenteral nutrition supply kit; premix, per day
- B4222 – Parenteral nutrition supply kit; home mix, per day
- B4224 – Parenteral nutrition administration kit, per day

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

Refer to the enteral nutrition and parenteral nutrition LCDs and their related policy articles for additional information.
For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time (CT), Monday through Friday, or email the PDAC by LCD for Parenteral Nutrition (L33798) completing the DME PDAC Contact Form.

Related Content

- Enteral Nutrition - Policy Article - Effective October 2015 (A52493)
- LCD for Enteral Nutrition (L33783)
- LCD for Parenteral Nutrition (L33798)
- Parenteral Nutrition - Policy Article - Effective October 2015 (A52515)
- PDAC Contact Form

Enteral Nutrition – Third Quarter 2015 Widespread Prepayment Review Update

Jurisdiction B continues to conduct a widespread prepayment medical review of enteral nutrition, which includes the following Healthcare Common Procedure Coding System (HCPCS) B4035.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 148 claims. A total of 36 claims were allowed and 112 claims were denied, resulting in a claim error rate of 75.68 percent. A total of 23 claims were denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q2015</td>
<td>54</td>
<td>62.96%</td>
</tr>
<tr>
<td>2Q2015</td>
<td>143</td>
<td>67.10%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>148</td>
<td>75.68%</td>
</tr>
</tbody>
</table>

Data collected during the third quarter identified the top denial reasons as:

- The refill request documentation was not received.
- Beneficiary’s medical records did not demonstrate that the item was reasonable and necessary prior to the initial order.
- Medical necessity of pump (B9000–B9002) not documented.
- Medical necessity for special enteral formulas not shown.
- No proof of delivery from the supplier.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on the HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

You can quickly obtain additional details about the reason for a complex or noncomplex medical review denial view by using the Medical Review Denial Tool, which is available on the our website. To use the
tool, enter the 14-digit claim control number (CCN) from your remittance advice, in the CCN form field and select Submit. Select Reset to enter information for a new CCN. The Medical Review Denial Tool is available on our website under Supplier Resources, then Calculations & Tools.

To help avoid errors and ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.

Related Content
- Calculators & Tools
- CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15
- Jurisdiction B Supplier Manual
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

Mobility/Respiratory

MOBILITY

Current Top Reasons for Nonaffirmed Prior Authorization Request

The seven-element order contains an invalid date of the face-to-face (F2F) examination.

1. The F2F examination received was insufficient and did not contain enough information to satisfy the requirements Medicare has established for the power mobility device (PMD).
2. Key areas of the F2F examination that lack the necessary Medicare requirements for PMDs include:
   a. The F2F examination does not indicate the beneficiary is able to operate the tiller steering system of the PMD.
      i. The F2F examination does not indicate that the beneficiary has the physical and/or mental capability to safely operate the PMD being requested.
      ii. The F2F examination does not indicate that the beneficiary’s limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs).
      iii. The F2F examination does not indicate the beneficiary is able to safely transfer to and from the PMD.
      iv. The F2F examination does not indicate that the use of a POV has been excluded.
      v. The F2F examination does not indicate the beneficiary’s mobility limitations that would establish significant impairment to participate in MRADLs within their home.
      vi. The F2F examination does not indicate the beneficiary is able to maintain postural stability and position while operating the PMD in their home.
      vii. The F2F examination does not indicate the use of the PMD will significantly improve the beneficiary’s ability to participate in MRADLs and the beneficiary will use the PMD in their home.
      viii. The F2F examination requires a date stamp (or equivalent) to document the receipt date of the examination by the supplier.
RESPIRATORY

Oxygen and Oxygen Equipment – Third Quarter 2015 Widespread Prepayment Review Update

Jurisdiction B (JB) continues to conduct a widespread prepayment medical review of oxygen and oxygen equipment, which includes the following Healthcare Common Procedure Coding System (HCPCS) E0431.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 162 claims. A total of 25 claims were allowed and 137 claims were denied, resulting in a claim error rate of 84.57 percent. A total of 5 claims were denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4Q2014</td>
<td>296</td>
<td>90.20%</td>
</tr>
<tr>
<td>1Q2015</td>
<td>342</td>
<td>89.18%</td>
</tr>
<tr>
<td>2Q2015</td>
<td>383</td>
<td>82.80%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>162</td>
<td>84.57%</td>
</tr>
</tbody>
</table>

Data collected during the third quarter identified the top denial reasons as:

- The Affordable Care Act written order prior to delivery documentation did not clearly indicate the supplier’s date of receipt.
- The detailed written order is required before delivery.
- Beneficiary was not in a chronic stable state during blood gas study.
- The ordering provider’s National Provider Identifier (NPI) does not match the provider’s NPI on the submitted claim.
- Undetermined lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on the HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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To help avoid errors and ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.
Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea – Third Quarter 2015 Widespread Prepayment Review Update

Jurisdiction B (JB) continues to conduct a widespread prepayment medical review of positive airway pressure (PAP) devices for the treatment of obstructive sleep apnea, which includes the following Healthcare Common Procedure Coding System (HCPCS) E0601 KJ.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 199 claims. A total of 45 claims were allowed and 154 claims were denied, resulting in a claim error rate of 77.39 percent. A total of 17 claims were denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2Q2015</td>
<td>166</td>
<td>80.50%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>199</td>
<td>77.39%</td>
</tr>
</tbody>
</table>

Data collected during the third quarter identified the top denial reasons as:

- The Affordable Care Act written order prior to delivery documentation did not clearly indicate the supplier’s date of receipt.
- No objective evidence of adherence to use of the PAP device that has been reviewed by the treating physician.
- No documentation of a clinical re-evaluation between days 31 and 91 after initiating therapy.
- The detailed written order is required before delivery.
- The beneficiary did not have a face-to-face clinical evaluation by the treating physician prior to a sleep test.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on the HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”
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**Related Content**
- Calculators & Tools
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15
- Jurisdiction B Supplier Manual
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

**Other Durable Medical Equipment**

**Correct Coding and Coverage of Ventilators**

**Joint Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Publication**

This article has been revised to reflect changes to the 2016 Healthcare Common Procedure Coding System (HCPCS) codes used for billing Medicare for ventilators. These code changes are effective for claims with date of service (DOS) on or after 1/1/2016.

Ventilator technology has evolved to the point where it is possible to have a single device capable of operating in numerous modes, from basic continuous positive pressure (continuous positive airway pressure [CPAP] and bi-level positive airway pressure [PAP]) to traditional pressure and volume ventilator modes. This creates the possibility that one piece of equipment may be able to replace numerous and different pieces of equipment. Equipment with multifunction capability creates the possibility of errors in claims submitted for these items. This article will discuss the application of Medicare proper coding and payment rules for ventilators.

**HCPCS Coding**

Effective for claims with dates of service on or after 1/1/2016, the following HCPCS codes have been deleted from the HCPCS Code set:

- E0450 – Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)
- E0460 – Negative pressure ventilator; portable or stationary
- E0461 – Volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface (e.g. mask)
- E0463 – Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube)
- E0464 – Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask)
Claims for DOS after the effective date using these codes will be denied as “invalid code”.

Effective for claims with DOS on or after 1/1/2016, all products classified as ventilators must be billed using one of the following HCPCS codes:

- E0465 – Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
- E0466 – Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)

Products previously assigned to HCPCS codes E0450 and E0463 must use HCPCS code E0465. Products previously assigned to HCPCS codes E0460, E0461 and E0464 must use HCPCS code E0466. The Pricing, Data Analysis and Coding (PDAC) will update the product classification listing in a future update.

Note: Ventilators must not be billed using codes for CPAP (E0601) or bi-level PAP (E0470, E0471, E0472). Using the CPAP or bi-level PAP HCPCS codes to bill a ventilator is incorrect coding, even if the ventilator is only being used in CPAP or bi-level mode (see below). Claims for ventilators used in CPAP or bi-level PAP scenarios will be denied as incorrect coding.

Coverage

Items may only be covered based upon the applicable reasonable and necessary (R&N) criteria applicable to the classification assigned to the device. The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual Publication 100-03, Medicare NCD Manual, Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for the following conditions:

[N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These disease groups may appear to overlap conditions described in the respiratory assist devices local coverage determination (LCD) but they are not overlapping. Choice of an appropriate device i.e., a ventilator versus a bi-level PAP device is made based upon the severity of the condition. CMS distinguished the use of respiratory product types in a National Coverage Analysis Decision Memo (CAG-00052N) in June 2001:

RADs [bi-level PAP devices] provide noninvasive positive pressure respiratory assistance (NPPRA). Note that some studies in the literature refer to this as noninvasive positive pressure ventilation (NPPV).

NPPRA is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access. It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of respiratory support leads to death.

The conditions described in the respiratory assistance devices (RAD) local coverage determination are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death. The RAD policy describes clinical conditions that require intermittent and relatively short durations of respiratory support. Thus, a ventilator would not be eligible for reimbursement for any of the conditions described in the RAD LCD even though the ventilator equipment may have the capability of operating in a bi-level PAP (E0470, E0471, E0472) mode. Bi-level PAP devices (E0470, E0471) are considered as R&N in those clinical scenarios.
A ventilator would not be considered R&N for the treatment of obstructive sleep apnea, as described in the PAP LCD, even though the ventilator equipment may have the capability of operating in a CPAP (E0601) or bi-level PAP (E0470) mode.

Claims for ventilators used for the treatment of conditions described in the PAP or RAD LCDs will be denied as not reasonable and necessary.

**Upgrades**

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare’s coverage requirements. In some cases, CMS policy that allows for billing of upgrade modifiers can be used when providing an item or service that is considered beyond what is medically necessary. This is not applicable to ventilators in the situations described above.

Although the use of a ventilator to treat any of the conditions contained in the PAP or RAD LCDs is considered “more than is medically necessary”, the upgrade billing provisions may not be used to provide a ventilator for conditions described in the PAP or RAD LCDs. CPAP and bi-level PAP items are in the Capped-Rental payment category while ventilators are in the Frequent and Substantial Servicing payment category. Upgrade billing across different payment categories is not possible.

**Pricing Category**

Ventilators are classified in the Frequent and Substantial Servicing (FSS) payment category. FSS item are those for which there must be frequent and substantial servicing in order to avoid risk to the patient’s health. CMS designates the items which fall into this payment group. The monthly rental payment for items in this pricing category is all-inclusive meaning there is no separate payment by Medicare for any options, accessories or supplies used with a ventilator. In addition, all necessary maintenance, servicing, repairs and replacement are also included in the monthly rental. Claims for these items and/or services will be denied as unbundling.

**Coverage of Second Ventilator**

Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary - same/similar equipment.

Backup equipment must be distinguished from multiple medically necessary items which are defined as, identical or similar devices each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make a separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the beneficiary’s medical needs.

The following are examples of situations in which a beneficiary would qualify for both a primary ventilator and a secondary ventilator:

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.
- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.
Refer to the PAP and RAD LCDs and related policy articles and to the *Jurisdiction B (JB) Supplier Manual* for additional information on coverage, coding and documentation of these items.

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 email the PDAC by completing the DME PDAC Contact Form located on the PDAC website.

**Related Content**

- *JB Supplier Manual*
- LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)
- LCD for Respiratory Assist Devices (L33800)
- PDAC Contact Form
- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article - Effective October 2015 (A52467)
- Respiratory Assist Devices - Policy Article - Effective October 2015 (A52517)

### Pressure Reducing Support Surfaces-Group 2 – Third Quarter 2015 Widespread Prepayment Review Update

Jurisdiction B continues to conduct a widespread prepayment medical review of Pressure Reducing Support Surfaces-Group 2, which includes the following Healthcare Common Procedure Coding System (HCPCS) code E0277.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 236 claims. A total of 71 claims were allowed and 165 claims were denied, resulting in a claim error rate of 69.92 percent. A total of 25 claims were denied because documentation was not received in a timely manner.

<table>
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<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
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<tr>
<td>4Q2014</td>
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<td>81.20%</td>
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<tr>
<td>1Q2015</td>
<td>186</td>
<td>61.29%</td>
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<tr>
<td>2Q2015</td>
<td>190</td>
<td>72.11%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>236</td>
<td>69.92%</td>
</tr>
</tbody>
</table>

Data collected during the third quarter identified the top denial reasons as:

- No use of a group 1 support surface.
- Insufficient documentation of large or multiple stage III or stage IV pressure ulcers on trunk or pelvis (ICD 707.02–707.05) that have not improved over the past month.
- The medical documentation contains a missing signature.
- The medical record documentation contains a physician’s signature that does not comply with the CMS signature requirements outlined in Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual*, 3.3.2.4.
- No care plan established by the physician or home care nurse.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on this HCPCS code through complex medical review.
You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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To help avoid these sorts of errors and to help ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.

Related Content
- Calculators & Tools
- CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15
- Jurisdiction B Supplier Manual
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

Correct Coding – Face-Down Positioning Devices

Joint Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Publication

This article was originally published in 2003 and is being republished as a reminder to suppliers on the correct coding and coverage of these devices.

Following vitrectomy and certain other eye surgery procedures, patients are instructed to position themselves with their face down through most of the day. There are certain devices that facilitate this positioning. Examples (not all-inclusive) are a face cushion that is attached to a frame that can rest on a table or be positioned on a bed, or a cushion pad that is attached to a chair-like device.

The Centers for Medicare & Medicaid Services (CMS) has confirmed that these devices are statutorily noncovered because they do not fall within a Medicare benefit category. These types of devices are considered “precautionary devices” and also can be used for purposes other than the treatment of an illness or injury. The denial is a coverage denial, not a medical necessity denial.

For dates of service prior to 1/1/2004, the face cushion and frame should be coded A9270 (Noncovered item or service). For dates of service on or after 1/1/2004, code E0190 (Positioning cushion/pillow/wedge, any shape or size) must be used. For all dates of service, the chair-like device should be coded as A9270.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (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 email the PDAC by completing the DME PDAC Contact Form located on the PDAC website.
Hospital Beds Widespread Prepayment Probe Review Update

Jurisdiction B (JB) conducted a widespread prepayment probe review of hospital beds, which included the following Healthcare Common Procedure Coding System (HCPCS) codes:

- E0294 hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
- E0260 hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
- E0301 hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
- E0303 hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress

On 11/15/2015 our Medical Review Department completed a complex review of 100 claims. A total of 30 claims were allowed and 70 claims were denied, resulting in a claim error rate of 70.00 percent.

Eleven claims denied because documentation was not received in a timely manner.

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<thead>
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<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probe</td>
<td>100</td>
<td>70.00%</td>
</tr>
</tbody>
</table>

Data collected during the review, identified the top denial reasons as:

- The claim denial is due to the requested records were not received.
- The Affordable Care Act written order prior to delivery documentation did not clearly indicate the supplier's date of receipt.
- No documentation supporting a medical condition that requires frequent changes in the body position or has an immediate need for a change in body position for a semi-electric hospital bed.
- No documentation supporting a medical condition that requires frequent changes in the body position or has an immediate need for a change in body position for a semi-electric hospital bed.
- The detailed written order did not include a detailed description of the item(s).

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, Medical Review will continue review of claims in a widespread targeted medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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To further assist you, we are able to provide you with an opportunity to participate in the Educational Review Request (ERR) Project. The ERR project is voluntary and helps you to determine if the
documentation you have obtained supports the coverage criteria outlined in the local coverage determination (LCD) and policy articles prior to claim submission.

The main objective of the project is to provide personalized education explaining the proficiencies and deficiencies of the documentation, and ultimately improve your ability to meet documentation requirements for future audits from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and other contracted entities. Please visit the Educational Review Request page on our website under the Compliance & Audits tab for more details about participating in the ERR project.

To help avoid errors and ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.

Related Content
- Calculators & Tools
- CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15
- Jurisdiction B Supplier Manual
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

Orthotics and Prosthetics/Therapeutic Shoes/Lenses

ORTHOTICS AND PROSTHETICS

Correct Coding – Ankle Orthoses, With or Without Joints, Prefabricated or Custom Fabricated Coding Verification Review

Joint Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Publication

The Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Workgroup released HCPCS codes effective 1/1/2016. Ankle orthosis codes L1902 and L1904 are revised to include reference to joints. The revised codes read:

- L1902 – Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf
- L1904 – Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated

Ankle orthoses (ankle gauntlet or similar) with joints historically have been listed on Durable Medical Equipment Coding System (DMECS) as L2999 (Lower extremity orthoses, not otherwise specified). All ankle gauntlets or similar orthoses with joints listed on DMECS as L2999 will be end dated effective 6/30/2016. All manufacturers must submit a new coding verification review application to the PDAC to reclassify those products currently listed as L2999.

The Pricing Data Analysis and Coding Contractor (PDAC) coding verification application required is the orthotics application. This application is located on the PDAC website.

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 (CT), Monday through Friday, or email the PDAC by completing the DME PDAC Contact Form located on the PDAC website.
The ankle-foot/knee-ankle-foot orthosis local coverage determination (LCD) will be updated with these code narrative revisions at a future date.

**Related Content**
- LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses (L33686)
- PDAC Contact Form
- Request Code Verification

**Correct Coding – IDEO™ and ExoSym™ Energy Storing Ankle-Foot Orthoses**

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Joint Publication

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

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

- L1945 – Ankle foot orthosis, plastic, rigid anterior tibial section (floor reaction), custom fabricated
- L2755 – Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only

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

Refer to the ankle foot orthosis/knee ankle foot orthosis (AFO/KAFO) local coverage determination (LCD) and related policy article for additional information about coverage, coding and documentation.

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

**Related Content**
- Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article - Effective October 2015 (A52457)
- LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses (L33686)

**Spinal Orthoses: TLSO and LSO (L27017) – Third Quarter 2015 Widespread Prepayment Review Update**

Jurisdiction B continues to conduct a widespread prepayment medical review of spinal orthoses, which includes the following Healthcare Common Procedure Coding System (HCPCS) L0450–L0640.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 289 claims. A total of 60 claims were allowed and 229 claims were denied, resulting in a claim error rate of 79.24 percent. A total of 62 claims were denied because documentation was not received in a timely manner.
Data collected during the third quarter identified the top denial reasons as:

- Current medical record documentation fails to indicate LCD coverage criteria have been met for the item ordered.
- The documentation submitted did not include proof of delivery for the item(s) billed.
- No medical records were submitted.
- The detailed written order did not include a detailed description of the item(s).
- A detailed written order was not submitted.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on the HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

You can quickly obtain additional details about the reason for a complex or noncomplex medical review denial view by using the Medical Review Denial Tool, which is available on the our website. To use the tool, enter the 14-digit CCN from your remittance advice, in the CCN form field and select Submit. Select Reset to enter information for a new CCN. The Medical Review Denial Tool is available on our website under Supplier Resources, then Calculations & Tools.

To help avoid errors and ensure that you are appropriately and properly reimbursed under Medicare, you should visit our website to obtain valuable educational resources.

**Related Content**

- Calculators & Tools
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15
- *Jurisdiction B Supplier Manual*
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics
GLUCOSE MONITOR

Glucose Monitors (L27231) – Third Quarter 2015 Prepayment Review (A4253) Update

Jurisdiction B (JB) continues to conduct a widespread prepayment medical review of glucose monitors, which includes the following Healthcare Common Procedure Coding System (HCPCS) code A4253.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 4,969 claims. A total of 65 claims were allowed and 4,904 claims were denied, resulting in a claim error rate of 98.69 percent. A total of 390 claims were denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>4Q2014</td>
<td>10,328</td>
<td>97.86%</td>
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<tr>
<td>1Q2015</td>
<td>12,366</td>
<td>98.90%</td>
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<tr>
<td>2Q2015</td>
<td>14,325</td>
<td>98.80%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>4,969</td>
<td>98.69%</td>
</tr>
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</table>

Data collected during the third quarter identified the top denial reasons as:

- No medical records were submitted.
- No medical documentation to support quantities of supplies that exceed the utilization guidelines.
- Incorrect use of modifier.
- No glucose testing logs or narrative in treating clinician’s progress notes to demonstrate why beneficiary is testing above utilization guidelines.
- The proof of delivery record did not include the beneficiary (or designee) signature.

Claims submitted with the incorrect modifier continue to be an issue. You are reminded that if the beneficiary is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a beneficiary who is not treated with insulin injections.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on this HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states the following: “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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Related Content

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- Jurisdiction B Supplier Manual
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

Glucose Monitors (L27231) – Third Quarter 2015 Prepayment Review (A4253KX) Update

Jurisdiction B continues to conduct a widespread prepayment medical review of glucose monitors, which includes the following Healthcare Common Procedure Coding System (HCPCS) code A4253KX. Other durable

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 786 claims. A total of 14 claims were allowed and 772 claims were denied, resulting in a claim error rate of 98.22 percent. A total of 64 claims were denied because documentation was not received in a timely manner.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
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</thead>
<tbody>
<tr>
<td>1Q2015</td>
<td>74</td>
<td>100%</td>
</tr>
<tr>
<td>2Q2015</td>
<td>56</td>
<td>100%</td>
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<tr>
<td>3Q2015</td>
<td>786</td>
<td>98.22%</td>
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</table>

Data collected during the third quarter identified the top denial reasons as:

- No medical documentation to support quantities of supplies that exceed the utilization guidelines.
- No medical records were submitted.
- The proof of delivery record did not include the beneficiary (or designee) signature.
- No medical documentation submitted demonstrating evaluation of diabetes control within the six months prior to ordering quantities of supplies that exceed the utilization guidelines.
- The proof of delivery record did not include the delivery address.

Claims submitted with the incorrect modifier continue to be an issue. You are reminded that if the beneficiary is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a beneficiary who is not treated with insulin injections.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on this HCPCS code through complex medical review.
You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 15, which states the following: “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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UROLOGICAL AND OSTOMY SUPPLIES

Correct Coding – inFlow™ Intraurethral Valve-Pump (Vesiflo, Inc.)

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Joint Publication

Published 2/18/2016

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

Effective 1/1/2016, the inFlow™ Intraurethral Valve-Pump was assigned Healthcare Common Procedure Coding System (HCPCS) code A4335 (Incontinence supply, miscellaneous). This HCPCS code must be used on claims for initial issue of inFlow™, and is all-inclusive (catheter, wand and batteries). In addition, claims for replacement catheters, batteries or wands must also use HCPCS code A4335.

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

Refer to the urological supplies local coverage determination and related policy article for additional information on coverage, coding and documentation.
For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time, Monday through Friday, or email the PDAC by completing the DME PDAC Contact Form.

**Urological Supplies – Third Quarter 2015 Widespread Prepayment Review Update**

Jurisdiction B continues to conduct a widespread prepayment medical review of urological supplies, which includes the following Healthcare Common Procedure Coding System (HCPCS) A4353.

Between 7/1/2015 and 9/30/2015, our Medical Review Department performed a complex review of 181 claims. A total of 31 claims were allowed and 150 claims were denied, resulting in a claim error rate of 82.87 percent. 38 claims were denied because documentation was not received in a timely manner.

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<th>Claims Reviewed</th>
<th>Claims Error Rate</th>
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<td>4Q2014</td>
<td>401</td>
<td>91.50%</td>
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<tr>
<td>1Q2015</td>
<td>345</td>
<td>91.59%</td>
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<tr>
<td>2Q2015</td>
<td>192</td>
<td>90.60%</td>
</tr>
<tr>
<td>3Q2015</td>
<td>181</td>
<td>82.87%</td>
</tr>
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Data collected during the third quarter identified the top denial reasons as:

- Beneficiary did not meet one out of five criteria per local coverage determination (LCD) for coverage of intermittent catheter kits (A4353).
- No history or document to show use of sterile intermittent catheters, (A4351 or A4352) with an individual packet of lubricant (A4332) when urinary tract infections occurred.
- The detailed written order did not include the frequency of use.
- Documentation did not show two urinary tract infections within 12 months prior to start A4353.
- The refill request documentation was not received.

Claims submitted from multiple suppliers were identified for review. Additional documentation was requested and the documentation received was reviewed to assure that all coverage criteria and documentation requirements were met. Based on the above results and findings, we will continue to monitor activity on the HCPCS code through complex medical review.

You are reminded that failure to respond to requests for additional documentation is in violation of supplier standard number 28, found in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15, which states “Under 42 CFR §424.516(f)(1), a provider or supplier that furnishes covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory, imaging services, or covered ordered/certified home health services is required to maintain documentation for 7 years from the date of service, and upon the request of CMS or a Medicare contractor, provide access to that documentation.”

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### Related Content
- Calculators & Tools
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 15
- *Jurisdiction B Supplier Manual*
- Medical Policy Center
- Medical Review Focus Areas
- Medical Review Denial Tool
- Medicare University Course List
- Policy Education Topics

### Jurisdiction B DME Contact Information

<table>
<thead>
<tr>
<th>National Government Services Website</th>
<th><a href="http://www.NGSMedicare.com">http://www.NGSMedicare.com</a></th>
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<tr>
<td></td>
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<tr>
<td><strong>HHS OMHA Centralized Docketing</strong></td>
<td></td>
</tr>
<tr>
<td>200 Public Square, Suite 1260</td>
<td></td>
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<tr>
<td>Cleveland, OH 44114-2316</td>
<td></td>
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<tr>
<td><strong>Advance Determination of Medicare Coverage</strong></td>
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<tr>
<td>National Government Services</td>
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</tr>
<tr>
<td>Attn: Medical Review—ADMC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 7018</td>
<td></td>
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<tr>
<td>Indianapolis, IN 46207-7018</td>
<td></td>
</tr>
<tr>
<td>Fax 317-595-4759</td>
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<tr>
<td><strong>Beneficiary Customer Care</strong></td>
<td></td>
</tr>
<tr>
<td>1-800-MEDICARE (1-800-633-4227)</td>
<td></td>
</tr>
<tr>
<td>TDD 317-841-4677</td>
<td></td>
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<tr>
<td><strong>All DMEPOS Paper Claims</strong></td>
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<tr>
<td>National Government Services</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 7027</td>
<td></td>
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<tr>
<td>Indianapolis, IN 46207-7027</td>
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<tr>
<td><strong>Coordination of Benefits</strong></td>
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<tr>
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<tr>
<td>P.O. Box 5041</td>
<td></td>
</tr>
<tr>
<td>New York, New York 10274-5041</td>
<td></td>
</tr>
<tr>
<td>800-999-1118</td>
<td></td>
</tr>
</tbody>
</table>
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.
Website http://www.cahabasafeguard.com

Freedom of Information (FOI)
P.O. Box 6131
Indianapolis, IN 46206-6131

Medicare Secondary Payer (MSP)
National Government Services, Inc.
17003 DME MAC MSP
P.O. Box 809273
Chicago, IL 60680-9273

Medicare Secondary Payer
P.O. Box 6036
Indianapolis, IN 46206-6036
(correspondence only)
National Supplier Clearinghouse
National Supplier Clearinghouse
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
Website http://www.C2Cinc.com

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 6025
Indianapolis, IN 46206-6036
Supplemental Resources

MLN Connects Provider eNews

- MLN Connects® Provider eNews for November 25, 2016
- MLN Connects Provider eNews for December 03, 2015
- MLN Connects Provider eNews for December 10, 2015
- MLN Connects Provider eNews for December 17, 2015
- MLN Connects Provider eNews for January 07, 2016
- MLN Connects Provider eNews for January 14, 2016
- MLN Connects Provider eNews for January 21, 2016
- MLN Connects Provider eNews for January 28, 2016
- MLN Connects Provider eNews for February 04, 2016
- MLN Connects® Provider eNews for February 11, 2016
- MLN Connects® Provider eNews for February 18, 2016
- MLN Connects® Provider eNews for February 25, 2016

Medicare Learning Network Matters Articles

- MM8822 – Reclassification of Certain Durable Medical Equipment HCPCS Codes Included in Competitive Bidding Programs (CBP) from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category
- MM9231 Revised – New and Revised Place of Service Codes (POS) for Outpatient Hospitals
- MM9239 – Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP)
- MM9254 – Intravenous Immune Globulin (IVIG) Demonstration: Payment Update for 2016
- MM9350 – 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
- MM9355 – New Nonphysician Specialty Code for Dentist
- MM9374 – Remittance Advice Remark and Claim Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update
- MM9410 – Update to Medicare Deductible, Coinsurance and Premium Rates for 2016
- MM9427 – Claim Status Category and Claim Status Code Update
- MM9431 – Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- MM9461 – Healthcare Provider Taxonomy Codes (HPTCs) April 2016 Code Set Update
- MM9474 – New Condition Code for Reporting Home Health Episodes with No Skilled Visits
- MM9477 – Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) – April 2016
- MM9488 – Manual Update to Pub. 100-04, Chapter 20, to Include Used Rental Equipment
- MM9491 – Payment Clarification for the Purchase of Used Inexpensive and Routinely Purchased Durable Medical Equipment (DME) when Previously Rented
- MM9536 – April 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- SE1128 Revised – Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program
- SE1417 Revised – Implementation of Fingerprint-Based Background Checks
Are You Receiving a CO-4 on Your Remittance Advice?

Are you receiving American National Standards Institute (ANSI) code CO-4 on your remittance advice (RA), if so, did you know the group code CO indicates this is a contractual obligation and that you are held financially responsible. You are not allowed to charge the beneficiary for these services.

ANSI code CO-4 is considered an unprocessable claim. The procedure code is inconsistent with the modifier used, or a required modifier is missing. The Remark Code N519 will appear on your RA and states the following: “Invalid combination of Healthcare Common Procedure Coding System (HCPCS) modifiers.” You are required to correct your claim and resubmit a new claim with the appropriate modifiers. Your claim is not afforded appeal or reopening rights.

Below are some examples of why you might be receiving ANSI code CO-4 on your remittance advice:

- Incorrect pricing modifier (NU, RR, UE) appended to a HCPCS code
- Incorrect capped rental modifier (KH, KI, KJ) appended to a HCPCS code
- Billing for an E0601KX (continuous positive airway pressure device) and the diagnosis does not indicate obstructive sleep apnea (OSA)
- Billing with the incorrect liter flow modifier(s) for oxygen – QF, QG, QH
- Local coverage determination (LCD) indicates claim lines will reject without the KX, GA, GZ or GY modifier and the claim line is missing a modifier

For a complete listing of the HCPCS modifiers, please consult the Jurisdiction B (JB) Supplier Manual, Chapter 14 “Level II HCPCS Codes and HCPCS Modifiers.” Additionally, specific instructions regarding modifier usage is located in the JB Supplier Manual, Chapter 15 “DMEPOS Payment Categories.” The LCDs and PAs 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 our website.

You 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 CMS national fee schedules. To search for HCPCS and modifier coding or to find out more about the DMECS, please visit the Pricing, Data Analysis, and Coding Contractor’s website.

Related Content

- JB Supplier Manual, Chapter 14 “Level II HCPCS Codes and Modifiers”
- JB Supplier Manual, Chapter 15 “DMEPOS Payment Categories”
- JB Supplier Manual, Chapter 17 “Benefit and Denial Categories”
- JB Supplier Manual, Chapter 20 “Appeals and Reopenings”
- Pricing, Data Analysis Coding Contractor
- Washington Publishing Company

Are You Receiving a CO-16 on Your Remittance Advice?

We recently conducted claim data analysis and American National Standards Institute (ANSI) code CO-16 continues to be the number one claim submission error. Group code CO indicates this is a contractual obligation and that you are held financially responsible. You are not allowed to charge the beneficiary for these services.
ANSI code CO-16 is considered an unprocessable claim. The claim lacks information which is needed for adjudication. You are required to correct your claim and resubmit a new claim with the appropriate information. Your claim is not afforded appeal or reopening rights.

Below are some examples of why you might be receiving ANSI code CO-16 on your remittance advice:

- Missing indication of whether the patient owns the equipment.
- The ordering/referring provider’s name is either incorrect on the claim or the ordering/referring provider is not certified through Provider Enrollment, Chain and Ownership System (PECOS).
- The ordering/referring provider has a term date on the PECOS file.
- Missing/incomplete/invalid procedure code(s). Either the HCPCS code is incorrect or the related modifier to the HCPCS code is incorrect.
- HCPCS code E0147 (walker) requires a narrative

The local coverage determinations (LCDs), policy articles and policy education topics may be accessed through our website by selecting the Policy tab, then click Medical Policy Center link.

**Related Content**

- Medical Policy Center
- Policy Education Topics
- Situations Requiring a Narrative Explanation in Item 19
- *JB Supplier Manual*, Chapter 17 “Benefit and Denial Categories”
- *JB Supplier Manual*, Chapter 20 “Appeals and Reopenings”
- Pricing, Data Analysis Coding Contractor

**Reminder: Manual Wheelchairs General Coverage Criteria**

A manual wheelchair for use inside the home (E1037–E1039, E1161, K0001–K0009) is covered if:

- Criteria A, B, C, D, and E are met; and
- Criterion F or G is met.

A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   1. Prevents the beneficiary from accomplishing an MRADL entirely, or
   2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
   3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

B. The beneficiary’s mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

D. Use of a manual wheelchair will significantly improve the beneficiary’s ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or
deficiency or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Related Content

- LCD for Manual Wheelchair Bases (L33788)

Clarification of the Policy for Competitively Bid Wheelchair Accessories Furnished with Noncompetitively Bid Wheelchair Base

Change Request (CR) 9272 is a clarification regarding claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with noncompetitively bid wheelchair base units to beneficiaries residing in competitive bidding areas (CBAs). As a result of this clarification, you may need to resubmit certain claims that Medicare previously denied.

Previously, if you submitted an unassigned claim for a competitively bid accessory that is used on a noncompetitively bid base, the claim was denied because the Competitive Bidding Program (CBP) editing in the shared system required claims with CBP items to be submitted as an assigned claim.

CR9272 revised this process. Medicare will allow an unassigned claim under the following conditions:

- The item is a competitively bid wheelchair accessory that is used with a noncompetitively bid wheelchair base; and
- The KY modifier is submitted with the claim

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will reprocess claims that were either incorrectly paid or denied in error for dates of service 7/1/2013 through 1/4/2016 when you resubmit such claims within six months from the implementation date of CR9272. The implementation date of CR9272 is 1/4/2016. The DME MACs will override the timely filing edits for these resubmitted claims.

As a reminder, if you billed directly to the beneficiary and received payment for claims, you must resubmit and return the payment to the beneficiary for the applicable overpayment amounts.

Related Content

- MM9272 – Clarification of the Policy for Competitively Bid Wheelchair Accessories Furnished with non-Competitively Bid Wheelchair Base Equipment
- MM8864 – Competitive Bidding Program (CBP): Correction to VIPS Medicare System (VMS) Processing of Wheelchair Accessory Claims for Round 2
- Medicare Claims Processing Manual, 100-04, Chapter 36, Competitive Bidding, Section 50.16

Submitting Your Claims to the Correct Medicare Contractor

Recently, we have seen an increase in claim submissions for beneficiaries that do not reside in our jurisdiction. Claim jurisdiction for durable medical equipment prosthetics, orthotics and supplies (DMEPOS) items is based upon the beneficiary’s address on file with the Social Security Administration (SSA).

In order to prevent unnecessary denials associated with submitting claims to the wrong Durable Medical Equipment Medicare Administrative Contractor (DME MAC) you should take the following steps:
1. As part of your intake process inform Medicare beneficiaries that if they move, and change their address on file with SSA that they should inform you of the change.

2. Periodically, verify what address is on file with SSA by asking the Medicare beneficiary.

3. Utilize NGSConnex to determine the correct DME MAC to submit your claims to.

Contact the Provider Contact Center at 866-590-6727, the Customer Care Representative (CCR) will not be able to provide the address on file with SSA, but will be able to advise which DME MAC should be billed based upon the information on file.

The Jurisdiction A contract is administered by NHIC. The states included in DME MAC Jurisdiction A are:

- Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont

The Jurisdiction B DME MAC contract is administered by National Government Services, Inc. The states included in DME MAC Jurisdiction B are:

- Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin

The Jurisdiction C DME MAC contract is administered by CGS. The states included in Jurisdiction C are:

- Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia and West Virginia

The Jurisdiction D DME MAC contract is administered by Noridian Healthcare Solutions. The states included in DME MAC Jurisdiction D are:

- Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming

Related Content
- NGSConnex
- Jurisdiction B Supplier Manual, Chapter 11 “Claim Filing Jurisdiction”


The Educational Review Request (ERR) project has expanded to include another medical policy: manual wheelchair bases. For the (K0001), standard manual wheelchair, a review of documentation will be offered for general manual wheelchair criteria as outlined in the local coverage determination (LCD) and policy article (PA) for manual wheelchair bases.

The ERR project is a voluntary, educational opportunity that will assist you in determining if the documentation you have obtained supports the coverage criteria outlined in the LCD and PA, prior to claim submission. The main objective is to offer suppliers an opportunity to receive personalized educational support with written results explaining the proficiencies and deficiencies of their documentation, and ultimately improving the outcome of their future claim submissions.

To begin participating, please visit the ERR website under the Compliance & Audits tab.
Submitting Complete Claims for Timely Filing

We have seen an increase of inquiries resulting from claims that have denied due to past timely filing, American National Standards Institute (ANSI) CO-29 and remark code N30. Medicare law prescribes specific time limits within which claims for benefits may be submitted. As a result of the Patient Protection and Affordable Care Act (PPACA), all complete claims with dates of services on or after 1/1/2010 must be filed within one calendar year after the date of service.

Claims that receive a CO-29 and remark code N30 denial should not be automatically submitted to redeterminations for appeal, unless there was a good cause reason that resulted in the delay of the submission of the claim. Good cause may be established if there are unavoidable circumstances that are beyond your control, such as major floods, fires, tornados and other natural catastrophes. The redetermination request must include all documentation to support the service and an explanation for the delay or other evidence which establishes the reason in the delay of submission of the claim.

It is imperative for your completed claims to be submitted within one year from the date of service of your claim. As a reminder, a completed claim is a claim that has not denied with CO-4 or CO-16 since these are considered unprocessable.

If you are unsure if you have appeal rights on your claim, your remittance advice will advise via the MOA code of MA01. If your claim does not have MA01, you do not have appeal rights on your claim.

E0147 Walker Billing Reminder

When Healthcare Common Procedure Coding System (HCPCS) code E0147 is billed, the claim must include the manufacturer’s name and product name/number. The information should be entered in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the American National Standards Institute (ANSI) X12N, version 5010A1 professional electronic claim format. The line note has a limit of 80 character spaces, so you should abbreviate when possible. If you have an Administrative Simplification Compliance Act (ASCA) waiver on file and submit the Centers for Medicare & Medicaid Services (CMS)-1500 paper claim form, you may report the information in Item 19 of the claim form.

A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for beneficiaries who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. The only walkers that may be billed using code E0147 are those products for which a written coding verification review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate durable medical equipment prosthetics, orthotics and supplies (DMEPOS) Product Classification List.

Claims submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) without the additional information required for adjudication will be rejected with ANSI code CO-16 with a reason code 11 which states, “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.” 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 details regarding coverage and documentation requirements can be found in the local coverage determination and policy article for walkers.

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 our website.

**Related Content**
- LCD for Walkers (L33791)
- PDAC Product Classification List
- Situations Requiring a Narrative Explanation in Item 19
- Walkers - Policy Article - Effective October 2015 (A52503)

**Competitive Bidding: KG Modifier**

Modifier KG was introduced in Round 1 Rebid for the National Competitive Bidding Program to identify when the same supply or accessory was furnished in multiple competitive bidding categories and when the same Healthcare Common Procedure Coding System (HCPCS) code could be used with both competitively bid and noncompetitively bid items. The KG modifier is only used for beneficiaries residing in a competitive bid area (CBA) and applied to future competitive bidding rounds. Understanding the correct usage of the KG modifier is important to avoid unnecessary claim denials or incorrect payments.

Accurate billing for the KG modifier is easy. All you need to do is go out to the Competitive Bidding Implementation Contractor (CBIC) HCPCS file, select the product category that the accessory or supply falls into, then look up the HCPCS code. If the KG modifier is required, it will be indicated next to the HCPCS code.

The Centers for Medicare & Medicaid Services (CMS) issued Medicare Learning Network (MLN) MM9059 and clarifies the proper use of modifiers KK, KG, KU and KW under the National Competitive Bidding Program. This article informs the supplier community that the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will allow claims for competitive bid items when billed with modifiers KK, KG, KU or KW only when the HCPCS modifier combination is listed as valid on the CBIC HCPCS file.

The DME MACs will return claims as unprocessable for competitive bid items when billed with modifiers KK, KG, KU or KW when the HCPCS modifier combination is not listed as valid on the CBIC HCPCS file. You will receive ANSI code CO-4 on your remittance advice. The procedure code is inconsistent with the modifier used or a required modifier is missing. You are required to correct your claim and resubmit a new claim with the appropriate information. Your claim is not afforded appeal or reopening rights.

CMS revised MLN Matters® MM9059 to include verbiage for remittance advice messages for adjusted claims. If during the course of an adjustment, the DME MACs identify claim lines containing HCPCS inappropriately billed with modifiers KK, KG, KU or KW, those claim adjustments will also be denied with ANSI code CO-4. Your remittance advice will also notify you if an overpayment occurred. Your claim is not afforded appeal or reopening rights.

As a reminder, in accordance with Medicare rules and regulations, all suppliers that submit claims for beneficiaries who reside in a CBA must appropriately use the modifiers designated for the National Competitive Bidding Program when submitting claims.
Related Content

- MLN Matters® MM9059
- DMEPOS Competitive Bidding Program Website

Competitive Bidding: KK Modifier

Modifier KK was used in Round 1 Rebid for the National Competitive Bidding Program to identify when the same supply or accessory was furnished in multiple competitive bidding categories, such as the standard power wheelchair product category and complex rehabilitative power wheelchair product category. Round 1 Rebid ended on 12/31/2013, therefore; the KK modifier should no longer be appended to any Healthcare Common Procedure Coding System (HCPCS) code on any claim billed to Medicare. Understanding the correct usage of the KK modifier is important to avoid unnecessary claim denials or incorrect payments.

The Centers for Medicare & Medicaid Services (CMS) issued Medicare Learning Network (MLN) MM9059 and clarifies the proper use of modifiers KK, KG, KU and KW under the National Competitive Bidding Program. This article informs the supplier community that the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will allow claims for competitive bid items when billed with modifiers KK, KG, KU or KW only when the HCPCS modifier combination is listed as valid on the CBIC HCPCS file.

The DME MACs will return claims as unprocessable for competitive bid items when billed with modifiers KK, KG, KU or KW when the HCPCS /modifier combination is not listed as valid on the CBIC HCPCS file. You will receive American National Standards Institute (ANSI) code CO-4 on your remittance advice. The procedure code is inconsistent with the modifier used or a required modifier is missing. You are required to correct your claim and resubmit a new claim with the appropriate information. Your claim is not afforded appeal or reopening rights.

CMS revised MLN Matters® MM9059 to include verbiage for remittance advice messages for adjusted claims. If during the course of an adjustment the DME MACs identify claim lines containing HCPCS inappropriately billed with modifiers KK, KG, KU or KW, those claim adjustments will also be denied with ANSI code CO-4. Your remittance advice will also notify you if an overpayment occurred. Your claim is not afforded appeal or reopening rights.

As a reminder, in accordance with Medicare rules and regulations, all suppliers that submit claims for beneficiaries who reside in a competitive bidding area (CBA) must appropriately use the modifiers designated for the National Competitive Bidding Program when submitting claims.

Related Content

- MLN Matters® MM9059
- DMEPOS Competitive Bidding Program Website

Competitive Bidding: KU and KW Modifier

Modifiers KU and KW are not currently authorized for supplier billing use and do not currently appear on the single payment file as valid for use with any durable medical equipment, prosthetic, orthotic, and supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) code for competitively bid and noncompetitively bid items. Understanding the correct usage of the KU and KW modifier is important to avoid unnecessary claim denials or incorrect payments.

The Centers for Medicare & Medicaid Services (CMS) issued Medicare Learning Network® (MLN) MM9059 and clarifies the proper use of modifiers KK, KG, KU and KW under the National Competitive Bidding Program. This article informs the supplier community that the Durable Medical Equipment
Medicare Administrative Contractors (DME MACs) will allow claims for competitive bid items when billed with modifiers KK, KG, KU or KW only when the HCPCS/modifier combination is listed as valid on the Competitive Bidding Implementation Contractor (CBIC) HCPCS file.

The DME MACs will return claims as unprocessable for competitive bid items when billed with modifiers KK, KG, KU or KW when the HCPCS/modifier combination is not listed as valid on the CBIC HCPCS file. You will receive American National Standards Institute (ANSI) code CO-4 on your remittance advice. The procedure code is inconsistent with the modifier used or a required modifier is missing. You are required to correct your claim and resubmit a new claim with the appropriate information. Your claim is not afforded appeal or reopening rights.

CMS revised MLN Matters® MM9059 to include verbiage for remittance advice messages for adjusted claims. If during the course of an adjustment, the DME MACs identify claim lines containing HCPCS inappropriately billed with modifiers KK, KG, KU or KW, those claim adjustments will also be denied with ANSI code CO-4. Your remittance advice will also notify you if an overpayment occurred. Your claim is not afforded appeal or reopening rights.

As a reminder, in accordance with Medicare rules and regulations, all suppliers that submit claims for beneficiaries who reside in a competitive bidding area must appropriately use the modifiers designated for the National Competitive Bidding Program when submitting claims.

**Related Content**
- MM9059 Revised – Use of Modifiers KK, KG, KU, and KW under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program
- DMEPOS Competitive Bidding Program Website

**1099-MISC Form Information**

All 1099 Forms for calendar year (CY) 2015 were mailed by 1/29/2016. You should receive your 1099 Forms within 7–10 business days from the date of the mailing.

We issued a 1099 reflecting payments made on the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) by Provider Transaction Access Numbers (PTANs) issued by the NSC for CY 2015. The 1099s are mailed to your address on file with the National Supplier Clearinghouse (NSC).

In accordance with the Internal Revenue Code, Section 6041A, the reporting requirements state that contractors are required to issue 1099-MISC Form to all suppliers that received payments in the aggregate of $600 or more within a calendar year.

If you received payment in the aggregate of $600 or more you will receive a single combined 1099 statement for all PTANs associated to each Tax ID Number (TIN).

If the address information or TIN listed on the 1099 Form is incorrect, you should contact the NSC at 866-239-9652 in order to correct your supplier records.

We established a dedicated line for you to call regarding your 1099-MISC Form if you have questions or feel the dollar amounts on the 1099 are incorrect. The telephone number is 877-232-1099. The hours of operation are Monday through Friday 8:00 a.m.–5:00 p.m. eastern time (ET). On Friday mornings from 8:30 a.m.–10:30 a.m. ET, the telephone line will be closed for training. This dedicated telephone line will remain in operation from 1/29/2016 until 4/18/2016.
Related Content

- National Supplier Clearinghouse

Break in Need Versus Break in Billing

Have you ever submitted a claim for a capped rental item, thinking the capped rental period would start over but instead you received an American National Standards Institute (ANSI) denial CO-4? The reason could be that you failed to properly report break in need (BIN) or a new capped rental isn’t warranted because a break in billing (BIB) occurred. To avoid these types of denials you need to understand the difference between a BIN and a BIB.

Break in Need (BIN)

For capped rental equipment, parenteral and enteral nutrition pumps and oxygen equipment during the 36-month capped rental period only, claims following an interruption due to BIN must include a narrative statement describing the reason for the interruption which shows that medical necessity in the prior episode ended.

The narrative must be in the following format: BIN MMDDYY MMDDYY DX DX

1. The abbreviation “BIN” for break in need
2. The “pick up” date and the “delivery” date
3. The beneficiary’s previous diagnosis code and the new diagnosis code

If the previous diagnosis code and the new diagnosis code are the same, indicate the reason for the BIN (i.e., patient’s condition improved to the point they no longer needed the item)

Break in Billing (BIB)

When a beneficiary’s admission to an inpatient stay overlaps the supplier’s “anniversary date”, the date of discharge from the inpatient stay becomes the new “anniversary date” for subsequent claims. The claim must include a narrative statement explaining the reason for the interruption and change in the anniversary date.

An example of the narrative statement would be: ADM TO SNF 010116 DISC 021516

Using the PWK segment is not always the best option for including additional claim information, since the use of the PWK segment does not guarantee that we will review the submitted paperwork. The narrative statement required for BIN and BIB must be reported in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format. There is a limit of 80 character spaces in the line note, so you should abbreviate when possible. The narrative/note segments of an electronic claim are currently available for you to include notes and information that may be important for the proper adjudication of the claim. The narrative/note segment continues to be available since the implementation of PWK segment.

Please refer to “Situations Requiring a Narrative Explanation in Item 19” and “Suggested Abbreviation List for Submitting Narrative Information” to assist you in using the narrative section of a claim. For additional information regarding BIN and BIB refer to the “Jurisdiction B DME MAC Interruptions in a Period of Continuous Use Flow Chart”.

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