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- Available on iOS and Android phones and tablets
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From the Medical Director

CGS is Calling – Don’t Hang Up!

The receptionist buzzes your extension and says “There’s someone on the phone and they say they’re from Medicare!” While some might panic, I would encourage you to take the call. CGS Provider Outreach and Medical Review staff are starting a new program of contacting suppliers to offer assistance and education. Called AESOP (Analyze and Educate Suppliers on Policies), the program is a collaboration between Provider Outreach and Education and Medical Review clinical staff to identify suppliers with moderately high error rates and proactively make contact. CGS believes these suppliers, with just a little help and encouragement through education and claim review assistance, can further reduce their error rate. CGS hopes that through participation in the AESOP program suppliers can reduce their error rate to the point of exclusion from additional claim audits.

So how does the program work? First, you’ll get a letter in the mail addressed to the company’s Corporate Compliance Officer. A specific CGS employee’s contact information will be included in the letter along with a request to contact him/her to set up a time to speak. This is where calling CGS back or answering the phone (if we reach out to you) becomes critical. CGS will set up a time to speak to you, and during the kick-off teleconference CGS will provide more in-depth information about the program and begin discussing company-specific data including:

- CGS’ audit process
- Peer comparison data and specific audit results (using a comparative billing report)
- Benefits of reducing error rate
- Risks of not reducing error rate
- Request for a voluntary corrective action plan to promote active supplier participation and investment in the program

CGS anticipates ongoing monthly contacts, including the opportunity for our CGS staff to review your documentation and answer questions. The CGS MR/POE staff will provide feedback on your progress through updated data on errors and to answer any questions. Suppliers who demonstrate improvement in their error rate, particularly those who complete a corrective action plan, will be given individual consideration for removal from audit, even if their error rate does not reach the required threshold for exclusion.

CGS believes there are many benefits of the AESOP program and it all starts with a phone call. Don’t be afraid to make the call or answer OUR call!

myCGS

What’s New in myCGS

Have you used myCGS (http://www.cgsmedicare.com/jc/mycgs/index.html) lately? If not, you may be surprised by all the recent enhancements we’ve made. Our goal is to provide the supplier community with the best online portal experience available. To meet that goal, we are continually adding new features and enhancements based on feedback that you, the myCGS users, provide. Over the last few months, we’ve introduced several new features, including:

- **CBA Information** – The Beneficiary Eligibility tab now includes the ability to search for Competitive Bidding Areas (CBAs) by zip code.
- **Beneficiary Information Transfer** – Beneficiary data now automatically carries from one tab to another.
- **Development Letter Dates in Claim Status Details** – If a claim is pending due to a development letter, you can now view the date the letter was sent and the date in which a response is due.
- **Change Password Link** – The initial myCGS splash screen (prior to log in) now includes a Change Password link. If you would like to change your password, click the link and follow the prompts in IACS.
- **Cross-Referenced (Corrected) HICNs** – The Beneficiary Eligibility screen now includes the ability to let you know when a cross-referenced (corrected) HICN is available.

At the time of this writing, several more enhancements are in the process of being implemented, including Prior Authorization status, which will allow you to view the status and outcome of your Prior Authorization requests.

To keep up to date with the latest myCGS news, as well as other important DME MAC news and information, be sure to subscribe to our ListServ (http://www.cgsmedicare.com/medicare_dynamic/is/001.asp).
We Want Your Feedback

We are currently working on several more exciting new features that we plan to add to myCGS later this year. Many of the features that we are adding are based on suggestions that we’ve received directly from myCGS users.

Do you have an idea that you would like to see in myCGS? If so, then we’d love to hear from you. myCGS includes two methods of providing feedback: a feedback module where you can tell us about your experiences in myCGS and send us your suggestions for improvement and a ForeSee (http://www.cgsmedicare.com/jc/education/video/foresee.html) web survey.

To access the feedback module, log in to myCGS and click on the “Feedback” link in the upper-right corner of the screen. The Foresee web survey will pop up on your screen automatically after you’ve logged into myCGS. Once completed, the survey will not pop up again for another 30 days.

Try myCGS Today!

Not a myCGS user? Why not give it a try? We think that you will find myCGS to be a fast and user-friendly application that will help you save time and money.

Visit our myCGS (http://www.cgsmedicare.com/jc/mycgs/index.html) page to get started today!

Find Claim Denial Explanations in myCGS

Did you know that myCGS (http://www.cgsmedicare.com/jc/mycgs/index.html) includes custom claim denial explanations?

Your Remittance Advice (RA) contains ANSI codes and explanations for denied claims, but these explanations tend to be generic. For times when you need more information about a claim denial than what your RA can provide, myCGS offers detailed explanations of claim denials that are written by CGS staff specifically for myCGS. These claim explanations are as specific as possible and include suggestions for what you can do to either correct or appeal the claim decision (when applicable). The explanations are based on the internal instructions that our Customer Service Representatives (CSRs) use to answer your questions when you call. So before calling our CSR line, we encourage you to try researching your denials in myCGS. It’s an easy way to save time and help you be more productive!

To view claim denial explanations in myCGS, follow these simple steps:

- Go to the Claims tab.
- Search for your claim by entering the HICN, beneficiary name (first and last), and date(s) of service.
- Once you’ve found the appropriate claim, click on the “View” button in the “Explanation” column. myCGS will then display a message about your claim denial.

Try myCGS Today!

Not a myCGS user? Why not give it a try? We think that you will find myCGS to be a fast and user-friendly application that will help you save time and money.

Visit our myCGS (http://www.cgsmedicare.com/jc/mycgs/index.html) page to get started today!

ICD-10

ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs) - Maintenance CR


MLN Matters® Number: MM 8691
Related Change Request (CR) #: CR 8691
Related CR Release Date: May 23, 2014
Effective Date: July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates)determined for ICD-10
Related CR Transmittal #: R1388OTN
Implementation Date: Implementation Date: July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented) (ICD-10 updates)to be determined for ICD-10
Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to National Coverage Determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, and CR8197. Links to related MLN Matters® Articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

- 20.5 ECU Using Protein A Columns
- 20.7 PTA
- 20.20 ECP Therapy
- 20.29 HBO Therapy
- 50.3 Cochlear Implants
- 70.2.1 Diabetic Peripheral Neuropathy
- 80.2 Photodynamic Therapy
- 80.2.1 OPT
- 80.3 Photosensitive Drugs
- 80.3.1 Verteporfin
- 100.1 Bariatric Surgery
- 110.8.1 Stem Cell Transplants
- 110.4 Extracorporeal Photopheresis
- 110.10 IV Iron Therapy
- 150.3 Bone Mineral Density
- 160.18 VNS
- 160.24 Deep Brain Stimulation
- 160.27 TENS for CLBP
- 190.1 Histocompatibility Testing
- 190.8 Lymphocyte Mitogen Response Assay
- 190.11 Home PT/INR
- 210.1 PSA Screening Tests
- 210.2 Screening Pap/Pelvic Exams
- 210.3 Colorectal Cancer Screens
- 250.4 Treatment for AKs
- 250.3 IVIG for Autoimmune Blistering Disease
- 250.5 Dermal Injections for Facial LDS

Background

The purpose of CR8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, etc. The requirements described in CR8691 reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR8691.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.


Partial Code Freeze Prior to ICD-10 Implementation


MLN Matters® Number: SE1240 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015.

Provider Types Affected

This MLN Matters® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2014 to October 1, 2015 by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision on the Internet.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012, October 1, 2013, and October 1, 2014, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173.
- No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and
- On October 1, 2016, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the ‘091510_Morning_Transcript’ file. This section appears on page 4 of the 78-page document.


Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- Medicare Fee-for-Service Provider Resources Web Page -This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/Medicare/Coding/ICD10/index.html and check back
regularly for access to ICD-10 implementation information of importance to you.  **Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.**

- **CMS Sponsored National Provider Conference Calls**
  - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) on the CMS website.


- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html), select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI) [http://www.wedi.org](http://www.wedi.org); and**
  - **Health Information and Management Systems Society (HIMSS) [http://www.himss.org/icd10](http://www.himss.org/icd10) on the Internet.**

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**Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492**


**MLN Matters® Number:** SE1408 Revised

**Related Change Request (CR) #:** 7492

**Related CR Release Date:** N/A

**Effective Date:** October 1, 2015

**Related CR Transmittal #:** N/A

**Implementation Date:** N/A

**Note:** This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

**Provider Types Affected**

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

**Provider Action Needed**

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.
Key Points of SE1408

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to http://www.cms.gov/Medicare/Coding/ICD10/index.html for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs))</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes/Details</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td></td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.</td>
<td></td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>*NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015. *See Note</td>
<td></td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td></td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>81X</td>
<td>Hospice - Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td></td>
</tr>
</tbody>
</table>
Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH/ TO Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach


MLN Matters® Number: SE1409 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on July 31, 2014, to show the new ICD-10 implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date.

Provider Types Affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.
Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

● CMS internal testing of its claims processing systems;
● Provider-initiated Beta testing tools;
● Acknowledgement testing; and
● End-to-end testing.

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

● Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
● Beta testing is performed by a separate Integration Contractor for 8 weeks; and
● Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) and Local Coverage Determination (LCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

● NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website;
● The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

Acknowledgement Testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange
(EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC’s website.

End-to-End Testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider’s receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available shortly. Volunteer submitters will be selected nationwide to participate in the end-to-end testing. The sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

Claims Submission Alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC’s website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work. In addition to showing the toll-free numbers, you will find your MAC’s website address at this site in the event you want more information on the free billing software or the MAC’s provider internet portals mentioned above.

How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database


MLN Matters® Number: SE1421 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on August 4, 2014, to show the new ICD-10 implementation date of October 1, 2015. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

This MLN Matters® Special Edition article is intended to convey information on how to access updates to International
Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD)

Background

MACs may develop an LCD to further define a National Coverage Determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC’s own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or noncovered services when the codes are integral to the discussion of medical necessity.

The MCD


Use the following steps to access the list of LCDs with ICD-10 codes:

1. On the CMS MCD Homepage, click on the “Indexes” tab at the top of the page;
2. Select “Local Coverage”;
3. Select one of the three display options for LCDs (“LCDs by Contractor,” “LCDs by State,” or “LCDs Listed Alphabetically”);
4. If you choose LCDs by Contractor, click on that link;
5. Select a MAC;
6. In the Document types, checkmark the square for “Future LCDs/Future Contract Number LCDs”;
7. Click the “Submit” button;
8. Click on the Contractor name; and
9. A list of Future Effective LCDs will display. Those LCDs with a 10/01/2015 Effective Date are ICD-10 LCDs.

Note:

1. The ICD-10 updates are labeled “future” as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. The 10/01/2014 Effective Dates were changed to 10/01/2015 in August 2014.

Printing Documents on the CMS MCD

All documents on the CMS MCD may be printed. Use the following steps to print a document:

1. Open the document; and
2. In the upper right-hand corner, click on the “Print” button or use “Control + P”. Alternatively, click on the “Need a PDF?” button and click on the “Save a Copy” icon on the bottom of your screen or use “Shift + Control + S”.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims


MLN Matters® Number: MM8401 Revised
Related Change Request (CR) #: CR 8401
Related CR Release Date: May 13, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2955CP
Implementation Date: January 6, 2014

Note: This article was revised on June 9, 2014, to emphasize that coding “CT” in front of the clinical trial number applies ONLY to paper claims. The “CT” is not to be coded on electronic claims. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled


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

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

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

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

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

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678) when a clinical trial claim includes:

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

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

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provider for inclusion of the trial number using the messages listed below.

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

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

### Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

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**Claim Status Category and Claim Status Codes Update**


- **MLN Matters® Number:** MM8684
- **Related Change Request (CR) #:** CR 8684
- **Related CR Release Date:** May 23, 2014
- **Effective Date:** October 1, 2014
- **Related CR Transmittal #:** R2967CP
- **Implementation Date:** October 6, 2014

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 8684 which informs the MACs of the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/) and [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/) on the Internet.

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All code changes approved during the June 2014 committee meeting will be posted on these sites on or about July 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes will be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR8684.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.


MLN Matters® Number: MM8730
Related Change Request (CR) #: CR 8730
Related CR Release Date: May 16, 2014
Effective Date: March 3, 2014
Related CR Transmittal #: R1385OTN
Implementation Date: June 17, 2014

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8730 to announce the three additional states that require the use of a licensed/certified orthotist or prosthetist for furnishing of P&O. The states are North Dakota, Iowa, and Pennsylvania.

Background

CMS issued Transmittal 656, CR3959 on August 19, 2005. This CR instructed Durable Medical Equipment Regional Contractors (DMERCs, since changed to DME MACs) to implement claims processing edits to ensure compliance with CMS regulations found at 42 CFR Section 424.57(c)(1). Such regulations require DMEPOS suppliers wishing to bill Medicare to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

As a result of CR3959, the DME MACs implemented an edit which was programmed to deny claims for prosthetics and certain custom-fabricated orthotics when those items were furnished by personnel who were not licensed/certified as a orthotist or prosthetist by the State in which they practice. At the time CR3959 was issued and the DME MACs implemented the edit, there were nine states requiring the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. Since that time, five additional states have instituted requirements for the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. These five states are Arkansas, Georgia, Kentucky, Mississippi, and Tennessee. CR8390 instructed the DME MACs to revise the programming edits so that Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR3959.

CR8730 requires DME MACs to revise the programming edits so that North Dakota, Iowa, and Pennsylvania are added to the logic, in accordance with CRs 3959 and 8390.

In the 17 states that have indicated that provision of prosthetics and orthotics must be made by licensed/certified orthotist or prosthetist, Medicare payment may only be made for prosthetics and certain custom-fabricated orthotics when furnished by physicians, pedorthists, physical therapists, occupational
therapists, orthotics personnel, and prosthetics personnel. These specialties will bill for Medicare services when State law permits such entity to furnish an item of prosthetic or orthotic using the following codes:

- Medical Supply Company with Orthotics Personnel – Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel – Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;
- Orthotics Personnel – Specialty Code 55;
- Prosthetics Personnel – Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel, and Pedorthists – Specialty Code 57;
- Physical Therapist – Specialty Code 65;
- Occupational Therapist – Specialty Code 67;
- Pedorthic Personnel – Specialty Code B2;
- Medical Supply Company with Pedorthic Personnel – Specialty Code B3;
- Ocularist – Specialty Code B5; and

If a supplier is located in one of the applicable states, that supplier must be properly enrolled with the National Supplier Clearinghouse (NSC) to ensure the correct specialty code(s) is on file in order to submit a claim to Medicare for the prosthetics and custom-fabricated orthotics. Failure to be properly enrolled will result in the claim being denied. A copy of the State license should be sent to the NSC if the supplier is in one of the seventeen states requiring a license.

If a supplier should need to update its' file with the correct specialty, the supplier must submit a “Change of Information” on Form CMS-855S to the NSC along with all applicable licenses or certifications. That form is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855s.pdf on the CMS website. The NSC is responsible for maintaining a central data repository for information regarding suppliers. The NSC transmits this repository to the four DME MACs. The effective date for the new or revised specialty code will not be applied retroactively.

Additional Information


To review the article related to CR8390, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8390.pdf on the CMS website.


If you have any questions, please contact your DME MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Clarification of Billing Instructions Related to the Home Health Benefit


MLN Matters® Number: MM8775
Related Change Request (CR) #: CR 8775
Related CR Release Date: June 20, 2014
Effective Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10
Related CR Transmittal #: R2977CP
Implementation Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.
Provider Action Needed

This article is based on Change Request (CR) 8775, which updates the “Medicare Claims Processing Manual,” to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Background

CR 8775 makes a variety of small changes to the “Medicare Claims Processing Manual”. These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to Home Health Consolidated Billing (HH CB) Instructions: In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the “Medicare Claims Processing Manual”. CR8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR8775, and you will find a link to that CR in the “Additional Information” section of this article.

2. Removal of References to the Home Health Advance Beneficiary Notice (HHABN): CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HH ABN. CR8775 makes conforming changes to Chapter 10 to remove references to the HHABN.

3. Conforming to National Standards: CR8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare’s Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

Note: MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Leaning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
Provider Types Affected

This MLN Matters® Special Edition Article is intended for Medicare Fee-For-Service (FFS) suppliers who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Power Mobility Devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What You Need to Know

PMDs includes power wheelchairs and Power-Operated Vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of Durable Medical Equipment (DME) for Medicare coverage purposes.

Power Operated Vehicles (POVs or scooters): Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (Motorized) Wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. Due to the demonstration’s early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington. These 19 States accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration States. The prior authorization request can be completed by the ordering physician/practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the “submitter.” The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration States:

- Group 1 Power Operated Vehicles (K0800-K0802 and K0812);
- All standard power wheelchairs (K0813 through K0829);
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843);
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855);
- Pediatric power wheelchairs (K0890-K0891); and
- Miscellaneous power wheelchairs (K0898).

Note: Group 3 complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary’s home. All relevant documentation to support Medicare coverage of the PMD
should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the 7 element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/ practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 2 business days. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non-affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states. CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare’s coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS Competitive Bidding Program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at [http://go.cms.gov/PADemo](http://go.cms.gov/PADemo) on the CMS website.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

**Key Points**

CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary’s address as reported to the Social Security Administration and recorded in Medicare’s Common Working File (CWF). This demonstration will expand to Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary’s medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary’s right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

**Additional Information**

**Intravenous Immune Globulin (IVIG) Demonstration - Implementation**


MLN Matters® Number: SE1424  
Related Change Request (CR) #: N/A  
Related CR Release Date: N/A  
Effective Date: N/A  
Related CR Transmittal #: N/A  
Implementation Date: N/A

**Provider Types Affected**

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services to Medicare beneficiaries who are participants in the IVIG demonstration. Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

**Provider Action Needed**

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of 10/01/2014, and will continue for three years, as long as funding remains available.

**Background**

Depending on the circumstances, traditional Fee-For-Service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive
the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound and is otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor’s office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

**IVIG Demonstration**

The “Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012” authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. In addition, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times, should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor’s office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

**Beneficiary Eligibility**

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (have a diagnosis of PIDD) under the traditional FFS Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.);
5. The place of service must be the beneficiary’s home or a
setting that is “home like”.

Billing Details

A new “Q” code has been established for services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration:

Q2052 – (Long Description) - Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.

Q2052 - (Short Description) - IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim and for the same date of service as the IVIG drug itself.

Specially pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the “J” code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be $300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient’s medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary’s state.

The following “J” codes represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammmaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same date of service and place of service code on the claim line as the IVIG (J code) for which it is applicable. If multiple administrations of IVIG are submitted on a single claim, each date of service must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a Group Code of CO (Contractual Obligation), a Remittance Advice Remarks Code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a Claim Adjustment Remarks Code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a Group Code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare Secondary Payer process as well.

How Beneficiaries can apply for the IVIG Demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claims processing systems.

CMS will conduct an initial enrollment period from 8/08/2014 – 9/12/2014. Completed applications must be received by NHIC, Corp. no later than 5:00 pm Eastern. Time on 9/12/2014 to be considered. Incomplete applications will be returned to the beneficiary and will not be reviewed.
Beneficiaries will be notified by 9/30/2014 whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at [http://www.medicarenhic.com](http://www.medicarenhic.com) or through the IVIG Demo Hot Line at: (844)-625-6284.

Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp
IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to:

Fax 781-741-3533

Additional Information

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

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[https://mycgswebportal.cms.gov/](https://mycgswebportal.cms.gov/)
Dear Physician:

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when the beneficiary meets all of the requirements set out in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) and related Policy Article (PA). This article reviews the blood oxygen testing requirements. Refer to the LCD and PA for information on additional payment criteria.

**Timing of Physician Visit and Testing**

For initial qualification testing scenarios, the beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification. In addition, the qualification testing must be performed within 30 days prior to the date of Initial Certification.

For oxygen initially prescribed at the time of hospital discharge, testing must be performed within the 2 days prior to discharge. This 2-day prior to discharge rule does not apply to discharges from nursing facilities.

**Qualifying Test Results**

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

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

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

**Qualification Tests**

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

- Arterial blood gas (ABG) measurement; or
- Pulse oximetry

Arterial blood gas measurements are more accurate and therefore are the preferred measurement method. When both ABGs and oximetry are performed on the same day, the ABG value must be used for reimbursement qualification.
Blood oxygen values may be obtained using a variety of techniques. The LCD describes the following as acceptable oximetry testing methods:

- At rest and awake - often referred to as “spot” oximetry
- During exercise – requires a series of 3 tests done during a single testing session:
  - At rest, off oxygen - showing a non-qualifying result
  - Exercising, off oxygen – showing a qualifying result
  - Exercising, on oxygen – showing improvement in test results obtained while exercising off of oxygen
- During sleep
  - Overnight sleep oximetry
    - May be done in hospital or at home. Refer to the LCD for detailed information about home overnight sleep oximetry.
  - Titration Polysomnogram
    - Must be used for beneficiaries with concurrent (OSA) in order to establish that the beneficiary is in the "chronic stable state"

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

**Chronic Stable State (CSS)**

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

- Other forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.
- Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.
- It is expected that virtually all patients who qualify for home oxygen coverage for the first time under these guidelines have recently been discharged from a hospital where they submitted to arterial blood gas tests. If more than one arterial blood gas test is performed during the patient’s hospital stay, the test result obtained closest to, but no earlier than two days prior to the hospital discharge date, is required as evidence of the need for home oxygen therapy. (Note: this is the only exception to the CSS requirement.)
- For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of an acute illness or an exacerbation of their underlying disease.


Sincerely,

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

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

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

Eileen M. Moynihan, MD, FACP, FACR 
Medical Director, DME MAC Jurisdiction D 
Noridian Healthcare Solutions
Supplier Exit from Oxygen Equipment Business – Revised

- Joint DME MAC Publication

Recently the Centers for Medicare & Medicaid Services (CMS) issued instructions to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to process claims for replacement oxygen and oxygen equipment in the event that a supplier exits the Medicare oxygen business, whether voluntarily or due to revocation of billing privileges, and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

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

Obligations of Exiting Supplier

Suppliers voluntarily exiting the program are strongly encouraged to provide a minimum of thirty (30) days notice to the beneficiary of their intention to no longer provide oxygen therapy services. This should be provided in writing and may take one of two forms:

- A letter to the beneficiary notifying them of the supplier’s intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur; or,
- Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

Suppliers exiting through revocation are not subject to the notification requirements suggested above.

Obligations of New Supplier

For suppliers who receive beneficiaries from providers who have exited the Medicare oxygen business, claims for replacement equipment must:

- For the first month claim, append the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
- Document in the narrative field of the claim that “Beneficiary acquired through supplier voluntarily exiting Medicare program” or similar statement.
- When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
- When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.
- Home health agencies billing using the UB-04 paper claim may report this information in Form Locator 80 (Remarks).

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

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier’s services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program; or,
Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.

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

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

1. New order;
2. New initial Certificate of Medical Necessity (CMN)
   a. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
   b. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the Oxygen LCD.


Reminder – Oxygen Equipment and Contents Delivery

Suppliers are reminded that they cannot require a beneficiary to pick up oxygen equipment and contents at the supplier’s location or a central dispensing facility. Requiring a beneficiary to pick up their oxygen equipment and contents is a violation of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards (42 CFR 424.57(c)) which states:

12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.

Delivery and service is an integral part of oxygen and durable medical equipment (DME) suppliers’ costs of doing business. As such, these costs have already been accounted for in the calculation of the fee schedules.

When the DME MACs have knowledge of suppliers requiring beneficiaries to pick up equipment, a referral will be made to the National Supplier Clearinghouse for further investigation of the Supplier Standard violation.

42 CFR PART 424.57 Link: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=d630a73ac8976675eb9da25f89f190b6&ty=HTML&h=L&r=SECTION&n=42y3.0.1.11.4.5.8
Ankle-Foot Orthoses - Walking Boots - Coverage and Coding Issues – Revised

Effective: August 1, 2014

HCPCS codes L4360, L4361, L4386 and L4387 describe an ankle-foot orthosis commonly referred to as a walking boot. Walking boots that are used to provide immobilization as treatment for an orthopedic condition or following orthopedic surgery are eligible for coverage under the Brace benefit. When walking boots are used primarily to relieve pressure, especially on the sole of the foot, or are used for patients with foot ulcers, they are non-covered - no benefit category. Medicare covers therapeutic shoes, as described in the Therapeutic Shoes for Persons with Diabetes local coverage determination (LCD), for the prevention and treatment of diabetic foot ulcers.

Suppliers must add a GY modifier to HCPCS code L4360, L4361, L4386 or L4387 if the walking boot is only being used for the treatment or prevention of a foot ulcer. The absence of a GY modifier indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery. Claims for HCPCS code L4360, L4361, L4386 or L4387 with a GY modifier will be denied as non-covered.

Prefabricated walking boots must be billed with HCPCS codes L4360, L4361, L4386 or L4387. Add-on codes must not be billed in addition to these HCPCS codes. Custom fabricated walking boots must be billed with HCPCS code L2999 and must be accompanied by information identifying the manufacturer and model name (if applicable), the indication(s) for use of the boot, and an explanation of why a prefabricated walking boot is not sufficient. Walking boots must not be billed with other AFO HCPCS codes, including but not limited to HCPCS codes L2106-L2116, or with HCPCS codes for therapeutic shoes.

For additional information on coding and documentation requirements, please review the appropriate LCD and Policy Article located at http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com/

Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding – Revised

Effective: August 1, 2014

In April 2003 the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) establishing coverage for functional electrical stimulation (FES) to enable spinal cord injured (SCI) patients to walk (see National Coverage Determinations Manual 100-3 Chapter 1, Part 2, Section 160.12 [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf]).

Functional electrical stimulation is a technique that uses electrical impulses to activate paralyzed or weak muscles in precise sequence. The FES device transmits these electrical impulses via surface electrodes in the same manner as neuromuscular electrical stimulation (NMES). For example, through selective and sequential stimulation of various lower extremity muscle groups, FES can enable spinal cord injured (SCI) patients to walk.

Coverage of NMES (other than FES) to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. There has been no change in coverage criteria when NMES is used to treat disuse atrophy.

COVERAGE OF FES

Medicare will consider coverage of FES for SCI patients who have completed a training program consisting of at least 32 physical therapy sessions with the device, over a period of three months.

Coverage for FES to enhance walking will be limited to SCI patients with diagnosis, ICD-9 code 344.1 (paraplegia - paralysis of both lower limbs), or (when implemented) one of the ICD-10 codes, G04.1 –Tropical spastic paraplegia, G82.21 Paraplegia, complete, G82.22 Paraplegia, incomplete, and with all of the following characteristics:

1. Persons with intact lower motor units (L1 and below) (both
muscle and peripheral nerve); and,

2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently; and,

3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction; and,

4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking; and,

5. Persons that can transfer independently and can demonstrate standing independently for at least three minutes; and,

6. Persons that can demonstrate hand and finger function to manipulate controls; and,

7. Persons with at least six-month post recovery spinal cord injury and restorative surgery; and,

8. Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and,

9. Persons who have demonstrated a willingness to use the device long-term.

Indications for FES other than to enable SCI patients to walk will be denied as not medically necessary.

The only settings where therapists with the sufficient skills to provide these services are employed in inpatient hospitals, outpatient hospitals, comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

**HCPCS CODING**

Two codes are used to bill for FES:

**E0764 FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM**

**E0770 FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/ OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED**

Note that HCPCS codes E0764 and E0770 represent the “entire system” for the FES devices. Therefore, individual components such as walkers, crutches or other supplies must not be billed separately.

Manufacturers of products billed with code E0770 must have the code(s) verified by the Pricing, Data Analysis, and Coding (PDAC). Currently, the only products that are coded E0770 are:

- WalkAide (Innovative Neurotronics)
- Odstock ODFS Pace FES System (Odstock Medical/ Boston Brace)
- NESS L300 and H200 devices (Bioness)

Code E0764 does not require code verification by the PDAC; however, currently the only product that is coded E0764 is the Parastep I (Sigmedics).

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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: [https://www.dmepdac.com/](https://www.dmepdac.com/).

**DOCUMENTATION REQUIREMENTS**

For E0770 to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DME MAC. This order must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DME MAC upon request. If the supplier bills for this item without first receiving the completed order, the item will be denied as not medically necessary. Items billed to the DME MAC before a signed and dated order has been received by the supplier must be submitted with an EY modifier (No physician or other health care provider order for this item or service) added to each affected HCPCS code.

If all the above criteria for coverage are met, HCPCS codes E0764 and E0770 must be billed with a KX modifier (REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET). If all the coverage criteria listed above are
not present, a KX modifier must not be added to the code.

The diagnosis code that describes the condition(s) requiring the use of FES must be added to the claim.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS
Effective for prescriptions dated on or after July 1, 2013

ACA 6407 contains provisions that are applicable to certain specified items in this NCD. The specified items are:

E0764 FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM

PRESCRIPTION REQUIREMENTS - WRITTEN ORDERS PRIOR TO DELIVERY

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0764. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. See below for information about the statutory requirements associated with a WOPD.

SPECIFIC DOCUMENTATION REQUIREMENTS

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items; therefore, a WOPD is required. Refer to the section below for information about these statutory requirements.

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

STATUTORY REQUIREMENTS

FACE-TO-FACE VISIT REQUIREMENTS

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD.
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier
- When required by state law

The first bullet, “For all claims for purchases or initial rentals”, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

PRESCRIPTION REQUIREMENTS

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician’s signature and signature date, and must be in the DMEPOS supplier’s possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary’s name
- Physician’s Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner’s National Provider Identifier (NPI)
The signature of the ordering practitioner
Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However, the prescriber must:

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription; and,
- Have documentation of the face-to-face examination that was conducted; and,
- Provide the DMEPOS supplier with copies of the in-person visit records.

DATE AND TIMING REQUIREMENTS

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier’s date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician’s signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

CLAIM DENIAL

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

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Republished July 10, 2014

Orthoses - Replacement of Components Clarification

The allowance for a prefabricated orthoses includes all components provided at the time of initial issue including, but not limited to, soft interfaces, straps, closures, etc. Replacements of components of covered orthoses are covered if the original component is no longer functional due to wear and cannot be repaired. Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are not covered.

Some replacement items have unique HCPCS codes. For example, replacement soft interfaces used with ankle contracture orthoses or foot drop splints are billed with HCPCS codes L4392 and L4394, respectively. One unit of service of the replacement interface HCPCS code is covered no more often than once every 6 months. Replacement components that do not have a unique HCPCS code must be billed with a “not otherwise specified” code - L1499, L2999, or L3999, whichever is applicable. The claim must include a description of the component provided, the reason for replacement, and the HCPCS code or narrative description of the base orthosis.
Note: HCPCS codes L4040-L4055 do not describe replacement soft interfaces used with contracture orthoses.

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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmpdac.com/

Orthoses/Prostheses - Coding for Professional Services/Fabrication Supplies

HCPCS codes L4205 (Repair of orthotic device, labor component, per 15 minutes) and L7520 (Repair of prosthetic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or prosthesis, respectively, or for medically necessary adjustments made more than 90 days after delivery.

HCPCS codes L4205 and L7520 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the patient
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual patient
- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Reimbursement for these services is included in the allowance for the HCPCS codes which describe the orthosis/prosthesis.

Similarly, HCPCS codes L4210 (Repair of orthotic device, repair or replace minor parts) and L7510 (Repair of prosthetic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis/prosthesis.

If a supplier decides to submit a claim for services/items that are included in the allowance for the orthosis/prosthesis, HCPCS code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. HCPCS code L9900 is denied as not separately payable.

Services or supplies associated with the provision of plaster or fiberglass casts or splints are in the jurisdiction of the local carriers and fiscal intermediaries. Claims for these items may not be submitted to the DME MAC.

Originally Published September 2004
Republished July 10, 2014

Positive Airway Pressure Device and Respiratory Assist Device - Nasal Interfaces and Liners – Revised

Effective: August 1, 2014

There are two types of nasal interfaces that are used with a Positive Airway Pressure (PAP) device or a Respiratory Assist Device (RAD) - a nasal mask and cannula-type interface.

Both of these types of products are coded A7034 (NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP). HCPCS code A7034 includes the soft interface at initial issue.

HCPCS codes A7032 (CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH) and A7033 (PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR) describe replacement soft interfaces. HCPCS code A7032 is used for a nasal mask interface that goes around the nose, but not into the nostrils. The unit of service for this HCPCS code is “each.” HCPCS code A7033 is used for a nasal cannula-type interface. This interface extends a short distance into the nostrils. The unit of service for this code is “pair.” For some products, there are two physically separate cushions or “pillows” - one for each nostril. Two cushions/pillows (i.e. “pair”) equals one unit of service of HCPCS code A7033. For other products, the interface is a single piece with two protrusions that extend into the nostrils. One of these interfaces equals one unit of service of HCPCS code A7033.

Liners are not interfaces for use with a PAP mask. Liners are products placed between the patient’s skin and the PAP mask
interface and are made of cloth, silicone or other materials. These are not considered “interfaces” as defined in the PAP Local Coverage Determination (LCD) and related Policy Article as described above. Liners must not be billed as replacement interface for a PAP mask using codes such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

A liner used in conjunction with a PAP mask is considered a comfort and convenience item and must be coded A9270 (Non-covered item or service). There is no additional payment for liners used with a PAP mask (see Medicare Benefit Policy Manual 100-2 Chapter 15 Section 110.1 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)).

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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com/.

Related Information:


Coverage and Correct Coding of Continuous Glucose Monitoring Devices

- Joint DME MAC Publication

Continuous glucose monitoring (CGM) devices measure glucose in the interstitial fluid, not capillary blood, providing interstitial glucose readings every few minutes. CGM systems are composed of several components - disposable sensors that are inserted in the subcutaneous tissue, a transmitter that relays information to the receiver, and a receiver where the information is displayed.

**COVERAGE**

Current CGM systems are FDA - approved only as a secondary source for glucose monitoring. According to the FDA labeled indications, all CGM device readings must be confirmed with a capillary blood glucose monitor and users are cautioned against making insulin dosage changes based solely on CGM system determinations. Consequently, CGM devices are considered precautionary equipment. The Medicare Durable Medical Equipment Benefit excludes precautionary items from coverage; therefore, claims for CGM systems are denied as statutorily non-covered, no benefit.

Medicare covers necessary supplies used with covered items. When the base item is non-covered, the related supplies are also not covered. Claims for supplies used with CGM systems are denied as statutorily non-covered, no benefit.

**CODING**

CGM systems are provided either as stand-alone systems or integrated into an insulin pump. For stand-alone systems and related supplies, use the following HCPCS codes:

A9276 - SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY

A9277 - TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

A9278 - RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM
CGM capability that is integrated into an insulin pump is considered as included in the coding for the infusion pump. Additional supplies necessary for CGM use are likewise included in the code for the infusion pump supplies. There is no separate or additional coding for CGM functions. The following HCPCS codes are used for insulin pumps and related supplies:

- E0784 - EXTERNAL AMBULATORY INFUSION PUMP, INSULIN
- A4221 SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)
- K0552 - SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH

Separately billing for a CGM system integrated into an infusion pump or related supplies are incorrect. Claims for separate billing will be denied as unbundling.


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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: [https://www.dmepdac.com/](https://www.dmepdac.com/)

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**Positive Airway Pressure (PAP) Devices - Continued Coverage beyond the First Three Months of Therapy - Policy Reminder**

- Joint DME MAC Publication

A review of recent appeals information has identified denials associated with demonstrating compliance with the PAP Local Coverage Determination (LCD) requirements for continued coverage after the initial three months rental. This article is intended as a review of those criteria.

**GENERAL REQUIREMENTS**

PAP is covered for beneficiaries with obstructive sleep apnea (OSA). The presence of OSA is documented by clinical evaluation and sleep testing. Refer to the LCD for a discussion of the requirements necessary to establish coverage with a diagnosis of obstructive sleep apnea.

Once the diagnosis of OSA is established, the initial three rental months are covered. But by the end of the first three months, there are additional requirements that must be met in order for equipment rental and supply payments to continue. Compliance with these requirements must be documented in the beneficiary’s medical record. When the requirements are not met, coverage for more than the first three months is not possible.

There are two requirements for continued coverage:

1. The treating physician must have an in-person visit with the beneficiary no sooner than the 31st day but no later than the 91st day after initiating therapy, conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

2. There must be objective evidence of the beneficiary’s adherence to the use of the PAP device. Adherence to therapy is defined as use of PAP ≥4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. This information must be reviewed by the treating physician and included in the medical record.

**FAILURE TO MEET PAYMENT REQUIREMENTS**

If the above criteria are not met, continued coverage of a PAP device and related accessories beyond the first three months...
is not possible. Claims for the fourth month and beyond will be denied as not reasonable and necessary.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:

1. Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

CHANGE IN EQUIPMENT

If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 does not change the length of the trial unless there is less than 30 days remaining in the trial period. If more than 30 days remain in the trial period, the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 and objective documentation of adherence on the E0470 would need to occur prior to the 91st day following initiation of the E0601. If less than 30 days remain in the trial period, the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601.

If an E0601 device was used for more than 3 months and the beneficiary was then switched to an E0470, the clinical re-evaluation must occur between the 31st and 91st day following the initiation of the E0470. There would also need to be documentation of adherence to therapy during the 3 month trial with the E0470.

DOCUMENTATION REQUIREMENTS

Both PAP devices (E0601 and E0740) are subject to the Affordable Care Act Section 6407 (ACA) requirements. The ACA requires that there be an in-person encounter with a healthcare provider sometime in the 6 months preceding the prescribing of the item. This visit must address some element of the underlying condition(s) that are the basis for the need for the item. The prescription must be a properly completed Medicare “Detailed Written Order”. This document is often referred to as a “Written Order Prior to Delivery (WOPD)”.

WOPD and the documentation of the face-to-face visit must be in the supplier’s file before delivery of the item can occur.

Suppliers are reminded that all Medicare coverage and documentation requirements for the PAP LCD also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.


Proof of Delivery – Requirements for Signature and Date

- Joint DME MAC Article

Auto-filling the date of delivery on delivery documentation or Proof of Delivery (POD) is a common business practice for many DMEPOS suppliers. Upon delivery, the Medicare beneficiary or designee is required to review the POD and must provide his or her signature, which signifies knowledge, approval and acceptance of the delivery. The Program Integrity Manual (PIM) chapter 4, section 4.26.1 “Proof of Delivery and Delivery Methods” (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf) does not state who may enter the date of delivery, but indicates that the date of signature must be the date in which the item was actually delivered. According to the PIM “…the date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee….” If the delivery documentation is signed by the beneficiary’s designee, the PIM also recommends noting the relationship of the designee to the beneficiary on the document.

Based on these instructions, the POD delivery date element is not required to be personally filled in by the beneficiary/designee. The date of delivery may be entered by the beneficiary, designee or the supplier. The date entered must be the actual date of delivery.

In the event that the supplier’s delivery documents have both a supplier entered date and the beneficiary or designee signature date on the POD document, the beneficiary/designee entered date is considered to be the delivery date and thus the date of service.
Electronic Health Records and Addenda

- Joint DME MAC Article

Recent DME MAC claim review experience has highlighted an issue with electronic health records (EHR) and documentation of additional clinical information that occurs following the initial beneficiary visit. The Centers for Medicare & Medicaid Services (CMS) refers to this additional information as amendments; however, similar principles as discussed below apply to corrections and delayed entries.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be mindful of the record keeping principles detailed below when providing records during the course of an audit request. Specifically, suppliers must ensure that if providing a medical record that has been amended or corrected, that the original medical record note is also provided to the requesting entity.

For reference, the Medicare Program Integrity Manual (Internet-only Manual 100-08), Chapter 3, Section 3.3.2.5 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf) provides the following guidance on amendments, corrections and delayed entries:

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such; and,
2. Clearly indicate the date and author of any amendment, correction or delayed entry; and,
3. Not delete but instead clearly identify all original content.

The above record keeping principles apply to all medical records, whether electronic or handwritten. However, the Program Integrity Manual also specifically addresses amendments, corrections and delayed entries in EHRs with the following instructions:

Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry; and,
b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

The manner in which an EHR system notates amendments and corrections can differ by software vendor; therefore, suppliers of (DMEPOS) must be careful when preparing their response to a record request and provide both the original record and any amendments that were made to the original note. Often in reviewing claim documentation, the Medical Review staff receives only the amended record with no indication of what was amended or corrected, when the change occurred or by whom the change was made. Failure to provide a complete medical note or a record with changes inconsistent with the CMS manual instructions may result in claim denial.

Related Article:
ACA 6407 Requirements – Corrections and Amendments to the Face-To-Face Visit and Written Order Prior to Delivery (WOPD)

- Joint DME MAC Article

The Affordable Care Act §6407 requires that the treating physician conduct a face-to-face examination and provide a written order prior to delivery (WOPD) for certain items of durable medical equipment (DME). When the supplier receives the documentation of the face-to-face visit and it does not describe a medical condition for which the DME is being prescribed or the WOPD is defective (i.e., missing a required element), the following instructions describe the options for remedy.

I. If errors in the face-to-face visit documentation or WOPD are found prior to delivery, the supplier has two options:
   A. The supplier may request that the treating physician amend the face-to-face visit notes or the WOPD, whichever is applicable, following the guidance in the Program Integrity Manual (Internet-Only Manual, Publ. 100-08, Chapter 3, Section 3.3.2.5 [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf]); or,
   B. A new face-to-face examination may be conducted or a new WOPD may be created, whichever is applicable.

II. If errors in the WOPD are found or the face-to-face visit notes do not describe a medical condition for which the DME is being prescribed and this is discovered after delivery of the item, the supplier has two options:
   A. If the error is discovered prior to claim submission, the original supplier may recover the delivered item(s), obtain a compliant, complete WOPD or face-to-face visit notes that describes a medical condition for which the DME is being prescribed, whichever is applicable, and then re-deliver the item(s) to the beneficiary; or,
   B. If the error is discovered after submitting a claim, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements.

Because the face-to-face visit and WOPD are statutory requirements, if there is a defective WOPD or the face-to-face visit notes do not describe a medical condition for which the DME is being prescribed, the claim will be denied and a beneficiary liability determination applied. Suppliers are strongly encouraged to review their WOPD documentation and the face-to-face visit notes carefully prior to delivery to ensure that all the requirements for coverage are met.

Vibration Therapy Devices - Correct Coding

- Joint DME MAC Publication

Vibration therapy is the application of a vibratory stimulation to the body. It can be applied as in a variety of ways, ranging from whole-body vibration to stimulation of local areas such as joints, hands, face, etc. (not all-inclusive). It is promoted as a treatment for numerous conditions such as arthritis, joint swelling, headache, neuropathic pain, restless legs, etc. (not all-inclusive).

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered “medical” equipment for which payment can be made under the Medicare program. This is true even though the item has some remote medically related use. Vibration devices are considered to be massage modalities. As such they are not eligible to be classified as Durable Medical Equipment. Claims for these items must be coded using:

A9270: Non-Covered Item or Service

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. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC web site: https://www.dmepdac.com/.
Dear Physician:

Recent DME MAC claim review experience has highlighted an issue with electronic health records (EHR) and documentation of additional clinical information that occurs following the initial beneficiary visit. The Centers for Medicare & Medicaid Services (CMS) refers to this additional information as amendments; however, similar principles as discussed below apply to corrections and delayed entries.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) often request your patient’s medical record in support of their claim to Medicare. When providing records, particularly those that have been amended or corrected, it is critical that you provide both the original note and any subsequent amendments or corrections to the original note.

For reference, the Medicare Program Integrity Manual (Internet-only Manual 100-08), Chapter 3, Section 3.3.2.5 ([http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)) provides the following guidance on amendments, corrections and delayed entries:

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such; and,
2. Clearly indicate the date and author of any amendment, correction or delayed entry; and,
3. Not delete but instead clearly identify all original content.

The above record keeping principles apply to all medical records, whether electronic or handwritten. However, the Program Integrity Manual also specifically addresses amendments, corrections and delayed entries in EHRs with the following instructions:

Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry; and,

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

The manner in which an EHR system notates amendments and corrections can differ by software vendor. Many electronic health records can be configured to deliver documentation which meets these requirements. If you are uncertain about the reports which are generated by your EHR, you are encouraged to consult with your organization’s EHR project team to ensure that these reports are being produced properly. In addition, you and
your staff are encouraged to be careful when preparing your response to a record request. Often in reviewing claim documentation, the Medical Review staff receives only the amended record with no indication of what was amended or corrected, when the change occurred or by whom the change was made. Failure to provide a complete medical note or a record with changes inconsistent with the CMS manual instructions may result in a claim denial and the inability for your DMEPOS supplier to provide the necessary equipment to accomplish your treatment goals.

Sincerely,

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

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

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

Eileen M. Moynihan, MD, FACP, FACR  
Medical Director, DME MAC Jurisdiction D  
Noridian Healthcare Solutions
Medical Policy

LCD and Policy Article Summary for June 12, 2014 – Drafts Released to Final

The following three draft Local Coverage Determinations and Policy Articles have been finalized:


Each of these medical policies will be effective for claims with dates of service on or after August 1, 2014. The notice period start date is June 12, 2014 and the notice period end date is July 31, 2014.

Please review each entire LCD and related Policy Article for coverage, coding and documentation requirements. Also review the Response to Comments Summary attached to each LCD.

LCD and Policy Article Revisions Summary for June 19, 2014

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

**Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)**

Revision Effective Date: 01/01/14 (June 2014 Publication)

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

- **Added:** Statement noting that Aprepitant is currently the only FDA approved NK-1 antagonist

**DOCUMENTATION REQUIREMENTS:**
- **Added:** Statement about adding V58.11 to each claim for codes J8501 and Q0181

**Power Mobility Devices**

Revision Effective Date: 10/01/2013 (June Publication)

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**
- **Clarification:** The face to face treating physician and prescribing physician requirements under ACA 6407 (Requirements effective 07/01/2013)

**CODING GUIDELINES:**
- **Clarification:** E0986 is all inclusive

**Wheelchair Options/Accessories**

Revision Effective Date: 07/01/2013 (June 2014 Publication)

**MISCELLANEOUS:**
- **Removed:** Requirement for accessories to be billed on the same claim as base

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

LCD and Policy Article Revisions Summary for July 24, 2014

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) and a Policy Article (PA) that have been revised and posted. Please review the entire LCD and related PA for complete information.

**Immunosuppressive Drugs**

Revision Effective Date: 10/01/2014

DOCUMENTATION REQUIREMENTS:
- Revised: Continued Need and Use Sections

Pressure Reducing Support Surfaces - Group 2 - Policy Article - Effective October 2014

Policy Article
Revision Effective Date: 10/01/2014

CODING GUIDELINES:
- Revised: E1399 Code Guidelines

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

Provider Outreach and Education is currently developing additional education on policy changes. We will issue a ListServ message as soon as the education is available.

Appeals

Filing an Appeal? Here Are Some Suggestions to Help You Avoid Common Mistakes

CGS has created this article to provide you with tips and important policy-based information to help you avoid common errors when filing an appeals request. When filing an appeal, you are requesting an additional review of your claim and the submitted documentation which you believe supports payment consideration. Before submitting an appeal, verify that your original claim was submitted correctly and that it followed all policy and billing requirements. If you determine that an appeal is an appropriate next step, it is very important that you include as much relevant information as possible. Below are some tips and reminders when filing an appeal:

Use the MR WIZARD self-service tool to verify specific denial information.

MR WIZARD was developed to assist suppliers with identifying claim line-specific information regarding Medical Review denials.

For decisions made on or after June 30, 2014, MR WIZARD will display the claim line level detail along with the reasons for denial. For decisions made February 1—June 30, 2014, MR WIZARD will only display the reasons for denial. MR WIZARD is available on the CGS website (http://www.cgsmedicare.com/medicare_dynamic/jc/denials.asp). Simply enter the Claim Control Number (CCN) to view customized information on the denial and resources available specific to the denial. MR WIZARD offers very detailed denial explanations for all types of medical review denials – including partial and full denials.

When using MR WIZARD to check for capped rental denials, it is important to remember that the CCN must be for the ORIGINAL claim denied by Medical Review. Entering the original CCN will provide you with complete denial information. MR WIZARD is also an excellent resource for additional information and education.

If your denial is for Oxygen or Diabetic supplies, you may have received a denial letter from CGS which also explains, in detail, the nature of the denial and any additional information which may be needed to support payment consideration.

CGS has created brief online videos (http://www.cgsmedicare.com/jc/education/Video/index.html) which provide important information on the MR WIZARD self-service tool and the Medical Review Denial letters. To view the videos, go to http://www.cgsmedicare.com/jc/education/Video/index.html.

Written Order Prior to Delivery (WOPD):

Certain DME items require a written order prior to delivery (WOPD). A WOPD is a standard Medicare detailed written order, which must be completed and in the DMEPOS supplier’s possession BEFORE the item is delivered. The prescription (order) for the DME must include all of the items below:

- Beneficiary’s name
- Physician’s Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item
- The prescribing practitioner’s National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
For certain specified items of durable medical equipment the Affordable Care Act requires that an in-person, face-to-face examination (F2F) documenting the need for the item must have occurred sometime during the six (6) months prior to the order for the item. For any of the specified items affected by this face-to-face requirement to be covered by Medicare, a written, signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a valid written order, it will be denied as statutorily non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, some of which are subject to these new order requirements. For example, oxygen concentrators (E1390) are often ordered in conjunction with portable oxygen (E0431). Orders for code E0431 require inclusion of the NPI while orders for E1390 do not.

CGS offers a variety of information and education on face-to-face and WOPD requirements, including:

- “Dear Physician Letter” Face-to-face and Written Order Requirements for High Cost DME (https://www.cgsmedicare.com/pdf/F2F_WO_Requirements_HighCostDME.pdf)

Miscellaneous Documentation Issues

When submitting your appeal, remember to provide all relevant documentation. Simply noting on your appeal that you have the information on file or that you’ve followed all requirements is not sufficient information to demonstrate that you have followed all billing requirements for a particular item or service. Here are some common errors you can avoid when submitting your appeal:

- Documentation - Documentation must be clear and readable. Submitted documents that are unreadable due to illegible handwriting or poor copy quality cannot be included in the appeals decision. Also, the documentation provided must be applicable to the item/service in question.
- Diabetic Supplies - Orders for diabetic supplies often do not specifically and clearly identify the items being ordered. Be specific and thorough in your appeals request.
- New Capped Rental Period - When billing for a new capped rental period, a pickup ticket for the previous equipment and additional documentation should be submitted. The documentation must include, but is not limited to:
  1. A description of the beneficiary’s prior medical condition that necessitated the previous item;
  2. A statement explaining when and why the medical necessity for the previous item ended; and
  3. A statement explaining the beneficiary’s new or changed medical condition and when the new need began.


- Certificate of Medical Necessity (CMNs) - Per the DME MAC Jurisdiction C Supplier Manual, Chapter 4-Certificates of Medical Necessity (CMN) (http://www.cgsmedicare.com/jc/pubs/pdf/chpt4.pdf), “For certain items or services billed to a DME MAC, you must receive a signed CMN from the treating physician. You must have a faxed, photocopied, original signed order or an electronic CMN in your records before you can submit a claim for payment to Medicare. CMNs and DIFs are referred to
by their CMS form numbers. The CMS form number is located in the bottom left corner of the form. DME MAC form numbers identify the CMN on electronic claims submitted to the DME MAC."

The correct CMN form and version (e.g., initial, revised, and recertification) must be submitted with the appeal request. A common error is for incorrect forms and versions of the CMN that are submitted with appeals requests. This is most evident for the Transcutaneous Electrical Nerve Stimulator (TENS) device.

- **PECOS** - Effective January 6, 2014, specific edits were implemented that prevent DMEPOS suppliers from receiving payment for items that have been prescribed by a physician who does not have current enrollment credentials in the Medicare Provider Enrollment, Chain and Ownership System (PECOS).

For any DMEPOS item to qualify for coverage by Medicare it must be ordered by a physician or a practitioner who is eligible to order such item. To be eligible:

1. Physicians or practitioners must be enrolled in PECOS; and
2. Must be registered in the system; and
3. Have a specialty that is eligible to order DMEPOS items for Medicare beneficiaries.

myCGS web portal allows you to validate a physician’s eligibility on a pre-claim basis. Only registered users of myCGS can access this information. It is the supplier’s responsibility to confirm the physician’s eligibility. For additional information, view the Dear Physician letter located at [https://www.cgsmedicare.com/jc/forms/pdf/dear_physician_pecos.pdf](https://www.cgsmedicare.com/jc/forms/pdf/dear_physician_pecos.pdf).

- **Home Oxygen Equipment** - The results of a blood gas study that has been ordered and evaluated by the attending physician are used as one of the criteria for determining Medicare reimbursement. Sufficient documentation regarding the blood gas study and test conditions is frequently missing from the appeal request. If you are submitting an appeal based on home oxygen equipment, please refer to the CMS Medicare Coverage Database, Local Coverage Determination (LCD) ID L11446-Oxygen and Oxygen Equipment (and [http://www.cgsmedicare.com](http://www.cgsmedicare.com) and [http://www.cms.gov](http://www.cms.gov)) for detailed information regarding oxygen testing. Also, refer to the article entitled “Revised: Payment Rules Reminder – Home Oxygen Initial Qualification Testing” [http://www.cgsmedicare.com/jc/pubs/news/2014/0114/cope24320.html](http://www.cgsmedicare.com/jc/pubs/news/2014/0114/cope24320.html).

Additional education is available in Medicare Minute ([http://www.cgsmedicare.com/jc/education/Video/index.html](http://www.cgsmedicare.com/jc/education/Video/index.html)), featuring Dr. Robert Hoover. The video provides detailed education on Oxygen equipment, testing, and the chronic stable state.

- **Nebulizer Drugs** - The written order prior to delivery (WOPD) submitted with appeal requests for nebulizer drugs is often missing information. Per the CMS Medicare Coverage Database, LCD ID L5007-Nebulizers, “The order for any drug must clearly specify the type of solution to be dispensed to the beneficiary and the administration instructions for that solution. The type of solution is described by a combination of (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container.”


Additional education is available in Medicare Minute ([http://www.cgsmedicare.com/jc/education/Video/index.html](http://www.cgsmedicare.com/jc/education/Video/index.html)), featuring Dr. Robert Hoover. The video provides detailed education on using the CGS Nebulizer Drug Calculator.

- **Positive Airway Pressure (PAP) Devices** – Appeal requests for claims for PAP devices and/or related accessories/supplies are often lacking all of the required documentation or the documentation submitted does not meet the policy guidelines. Accessories/supplies are not allowed when the base equipment has not met all of the guidelines. Remember, a face-to-face clinical evaluation conducted by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea should be submitted with the appeal request. The LCD contains very specific documentation requirements for replacement PAP devices. Please review the policy requirements and ensure the required documentation is included with your request. For all PAP devices the sleep test (Type I - IV, Other) must be interpreted by a physician who holds either:

1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or,
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or,

3. Completed residency or fellowship training by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or,

4. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM), Accreditation Commission for Health Care (ACHC), or The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations – JCAHO).

Additional Resources and Education:


Dr. Robert Hoover offers a two-part Medicare Minute ([http://www.cgsmedicare.com/jc/education/Video/index.html](http://www.cgsmedicare.com/jc/education/Video/index.html)) series on PAP which will help clarify billing questions.

- **Proof of Delivery** – Proof of delivery documentation does not provide a clear description of the item(s) delivered. Be sure the delivery documentation contains all the required elements as described in the applicable local coverage determination.

Additional education and information on a variety of policies is also available in the Medical Review section of CGSMedicare.com. Select “Claim Audit Resources” to review the policy-based information and resources.

### MSP Type Billed Correctly on Electronic Claims

Under the Medicare Secondary Payer (MSP) program, when you have determined another payer is primary to Medicare, a claim must first be submitted to the primary payer before the claim may be submitted to Medicare. In this situation, Medicare is considered the secondary payer.

When you identify that Medicare is the secondary payer, and you submit electronic claims, you must **properly** identify on the electronic claim the reason Medicare is the secondary payer. An MSP type code (often referred to as a reason code) indicating the reason for other coverage entitlement must be indicated on the ANSI 5010A1 within the 2000B SBR loop/segment.

**NOTE**: MSP type 47 should only be used when Medicare is secondary to Liability insurance. Failure to enter the correct MSP type may result in your claim rejecting.

<table>
<thead>
<tr>
<th>MSP Type Codes</th>
<th>DESCRIPTION OF REASON</th>
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<tbody>
<tr>
<td>12</td>
<td>Working Aged – Beneficiary/Spouse Group Health Plan</td>
</tr>
<tr>
<td>13</td>
<td>ESRD – Beneficiary in a Medicare Coordination Period with an Employer Health Plan</td>
</tr>
<tr>
<td>14</td>
<td>Auto Med/No Fault</td>
</tr>
<tr>
<td>15</td>
<td>Worker’s Compensation</td>
</tr>
<tr>
<td>16</td>
<td>Other Federal Programs – PHS, Other Federal Agency</td>
</tr>
<tr>
<td>41</td>
<td>Black Lung</td>
</tr>
<tr>
<td>42</td>
<td>Veterans Affairs</td>
</tr>
<tr>
<td>43</td>
<td>Disabled – Under Age 65 with LGHP</td>
</tr>
<tr>
<td>47</td>
<td>Liability (including FTCA)</td>
</tr>
</tbody>
</table>

The Center for Medicare & Medicaid Services (CMS) has created a questionnaire that contains questions that can be used to screen Medicare beneficiaries for other payers. We encourage you to use the CMS Sample Medicare Secondary Payer Questionnaire ([http://www.cgsmedicare.com/jc/forms/pdf/JC_msp_questionnaire.pdf](http://www.cgsmedicare.com/jc/forms/pdf/JC_msp_questionnaire.pdf)) to screen for payers primary to Medicare. Use of the CMS questionnaire will assist you in determining the applicable MSP provision and appropriate MSP type code.

Additional information regarding the coordination of Medicare benefits and the Medicare Secondary Payer Programs is located in Chapter 11 of the *DME MAC Jurisdiction C Supplier Manual* ([http://a70tpcgsisw003/dmercweb/DMERC/dmsm/Chpt11.htm](http://a70tpcgsisw003/dmercweb/DMERC/dmsm/Chpt11.htm)).
Update to Surety Bond Collection Procedures


MLN Matters® Number: MM8636
Related Change Request (CR) #: CR 8636
Related CR Release Date: May 16, 2014
Effective Date: June 17, 2014
Related CR Transmittal #: R517PI
Implementation Date: June 17, 2014

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment. Prosthetics, Orthotics and Supplies (DMEPOS) suppliers that submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and are required to obtain and maintain a surety bond as a condition of their enrollment in the Medicare program.

Provider Action Needed

This article is based on Change Request (CR) 8636, which outlines revised procedures to be used in the surety bond collection process. Be certain you are aware of these clarifications.

Background

For purposes of the surety bond requirement, 42 Code of Federal Regulations (CFR) section 424.57(a) defines an “unpaid claim” as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

Key Points of CR8636

The following describe the revised procedures involved in making a claim against a surety bond.

- If 45 days have passed since the initial demand letter was sent to the DMEPOS supplier, full payment has not been received, and the supplier has a surety bond, the DME MAC will (subject to the situations described in Pub. 100-08, chapter 15, section 15.21.7.1(A)(2)(b)(1) through (5)) send an “Intent to Refer” (ITR) letter to the supplier and a copy thereof to the supplier’s surety. The letter and copy will be sent no earlier than the 45th day and no later than the 60th day after the initial demand letter was sent.

- If the DME MAC does not receive full payment from the supplier within 30 days of sending the ITR letter (and subject to the situations described in Pub. 100-08, chapter 15, section 15.21.7.1(A)(2)(b)(1) through (5)), the contractor will notify the surety via letter that payment of the claim must be made to CMS within 45 days from the date of the surety letter. The DME MAC will send the surety letter no earlier than 30 days and no later than 75 days after sending the ITR letter.

- Between 8 and 12 calendar days after sending the surety letter, the DME MAC will contact the surety by telephone or e-mail to determine whether the surety received the letter.

- If the surety fails to make full payment within the 45-day timeframe, the DME MAC will (1) continue collection efforts and (2) notify the appropriate Center for Program Integrity (CPI) liaison via e-mail of the surety’s failure to make payment.

Additional Information

The official instruction regarding this change, CR 8636, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R517PI.pdf on the CMS website. Interested parties are strongly encouraged to read this instruction in full, as it contains additional information about the revised collection procedures.


Also, you may want to review MM6854 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6854.pdf which clarifies situations where surety bonds must be reported to the National Supplier Clearinghouse.

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update


MLN Matters® Number: MM8855
Related Change Request (CR) #: CR 8855
Related CR Release Date: July 24, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2996CP
Implementation Date: October 6, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8855 instructs the MACs to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use that software.

Background

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

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets, CARC and RARC, that must be used along with a Group Code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate Group Code must be reported. Additionally, for transaction 837 Coordination of Benefits (COB), CARC and RARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met.

MACs must make the necessary CARC/RARC code list updates on a regular basis. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare has the responsibility to implement code deactivation (making sure that any deactivated code is not used in original business messages), but the deactivated code in derivative messages is allowed. Medicare must be sure to not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR8855, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 8855 lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014; see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8703.pdf on the CMS website), and does not provide a
complete list of codes for these two code sets. The MACs must get the complete list for both CARC and RARC from the WPC website that is updated three times a year (around March 1, July 1, and November 1) to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts Remittance Advice code use.

You can find the WPC website, which has four listings available for both CARC and RARC, at http://wpc-edi.com/Reference on the Internet.

Changes in CARC List since CR 8703

The following tables list the changes in the CARC database since the last code update in CR8703. The full CARC list is available from the WPC website at http://wpc-edi.com/Reference on the Internet.

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<tr>
<th>New Codes – CARC</th>
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<th>Modified Codes – CARC</th>
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<th>Deactivated Codes – CARC</th>
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Changes in RARC List since CR 8703

The following tables list the changes in the RARC database since the last code update in CR8703. The full RARC list is available from the WPC website at http://wpc-edi.com/Reference on the Internet.

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<th>Modified Codes – RARC</th>
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Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

Medicare Remit Easy Print (MREP) Enhancement


**MLN Matters® Number:** MM8856  
**Related Change Request (CR) #:** CR 8856  
**Related CR Release Date:** August 1, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R1413OTN  
**Implementation Date:** January 5, 2015

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 8856. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare and Medicaid Services (CMS) to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR8856 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.
Background

CMS offers free software - Medicare Remit Easy Print (MREP) - to view and print HIPAA compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers and suppliers to help them transition to ERA. The MACs will notify MREP users of the MREP enhancements once implementation is complete. A key change in this latest version of the software is an enhancement to correct paging issues when a long claim runs to another page and that subsequent page was missing headers.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

Medicare Signature Requirements
- Educational Resources for Health Care Professionals


MLN Matters® Number: SE1419
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

Provider Action Needed

STOP — Impact to You

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

CAUTION — What You Need to Know

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

GO — What You Need to Do

Use this article as a reference to available educational resources related to signature requirements for Medicare-covered services.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

1. Medicare Quarterly Compliance Newsletter


2. Articles


physician’s signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

- **MM6261** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6261.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6261.pdf)): “Signature and Date Stamps for DME Supplies – Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)” alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.

- **MM6698** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf)): “Signature Guidelines for Medical Review Purposes” outlines the new rules for signatures and adds language of E-Prescribing beginning on or after April 16, 2010. The article covers signature logs and attestation statements. A helpful table summarizing examples where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit a signature log or attestation statement.

- **MM7337** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7337.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7337.pdf)): “Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation” states, if the narrative is part of the certification or recertification form it must be located immediately above the physician’s signature. If the narrative is an addendum to the form, (in addition to the physician’s signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician’s signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient.

- **MM8219** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf)): “Use of Rubber Stamp for Signature” highlights the exception for the use of rubber stamps in accordance with the Rehabilitation Act of 1973 in the case of the author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.


- **SE1308** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1308.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1308.pdf)): “Physicians Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)” addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.


3. Fact Sheets:


- **ICN 905364** ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf)): “Complying With Medicare Signature Requirements” provides answers to questions, as well as a list of resources, about Medicare signature
requirements.

  “Continuous and Bi-Level Positive Airway Pressure (CPAP/BPAP) Devices: Complying with Documentation and Coverage Requirements” states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

**Additional Information**


**Don’t Be Left Out!**

CGS Provider Outreach and Education offers up to 20 new webinars each month – and they are designed just for you! Our webinars are custom-built so they always include the most current information available on a variety of important topics ranging from billing trends to documentation requirements, policy updates, error rates and more! Registration for our webinars is easy and there is no limit to the number of webinars you may take. We also schedule our live webinars at various dates and times each month to maximize your opportunity to participate.

Our live, instructor-led webinars feature scenario-based education that tests your Medicare knowledge and billing skills – allowing you to learn by example. Plus, we provide you with important resources so you always have access to the current information you need to help successfully submit claims to the Medicare program.

CGS POE also provides one-on-one customized webinars for supplier offices who want specific education to assist with reducing errors. Just contact us for more information.

To explore this month’s webinar topics, simply click on the Education ([http://www.cgsmedicare.com/jc/education/index.html](http://www.cgsmedicare.com/jc/education/index.html)) menu and select Webinars ([http://www.cgsmedicare.com/jc/education/webinars.html](http://www.cgsmedicare.com/jc/education/webinars.html)) or Calendar of Events ([http://www.cgsmedicare.com/medicare_dynamic/wrkshp/DME_COE/DME_Report.asp](http://www.cgsmedicare.com/medicare_dynamic/wrkshp/DME_COE/DME_Report.asp)). We provide you with a complete list of current webinar education topics and schedules. We will also publish information through our regular ListServ announcements.

Remember, our webinars are customized just for you and feature the most current information available! Don’t be left out! Join the thousands of other Jurisdiction C suppliers who benefit from our unique scenario-based webinar education each month. Register ([http://www.cgsmedicare.com/jc/education/webinars.html](http://www.cgsmedicare.com/jc/education/webinars.html)) today!
Fees & Pricing

July 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files


MLN Matters® Number: MM8748
Related Change Request (CR) #: CR 8748
Related CR Release Date: April 25, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2936CP
Implementation Date: July 7, 2014

Provider Types Affected

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

Provider Action Needed

MACs will use the July 2014 Average Sales Price (ASP) and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2014, with dates of service July 1, 2014, through September 30, 2014.

Change Request (CR) 8748, from which this article is taken, instructs MACs to implement the July 2014 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised April 2014, January 2014, October 2013, and July 2013 ASP drug pricing files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS supplies the MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4, Section 50 (Outpatient PRICER)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website.

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
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<tbody>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
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<td>April 2014 ASP and ASP NOC</td>
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<td>January 2014 ASP and ASP NOC</td>
<td>January 1, 2014, through March 31, 2014</td>
</tr>
<tr>
<td>October 2013 ASP and ASP NOC</td>
<td>October 1, 2013, through December 31, 2013</td>
</tr>
<tr>
<td>July 2013 ASP and ASP NOC</td>
<td>July 1, 2013, through September 30, 2013</td>
</tr>
</tbody>
</table>

Additional Information


October 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files


MLN Matters® Number: MM8836
Related Change Request (CR) #: CR 8836
Related CR Release Date: July 18, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2990CP
Implementation Date: October 6, 2014

Provider Types Affected

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

Change Request (CR) 8836 instructs MACs to download and implement the October 2014 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2014, April 2014, January 2014, and October 2013, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 6, 2014, with dates of service October 1, 2014, through December 31, 2014. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, section 50, of the “Medicare Claims Processing Manual” which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf) on the CMS website. The following table shows how the quarterly payment files will be applied:

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<tr>
<td>October 2013 ASP and ASP NOC</td>
<td>October 1, 2013, through December 31, 2013</td>
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</table>

Note: CMS requires physicians and other providers to bill using the appropriate HCPCS or Current Procedural Terminology (CPT) code and to accurately report the units of service. Physicians and other providers should ensure the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy, as noted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html) on the CMS website.

Additional Information


October Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule


MLN Matters® Number: MM8865
Related Change Request (CR) #: CR 8865
Related CR Release Date: August 1, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3011CP
Implementation Date: October 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Hospice & Home Health MACs, and Durable Medical Equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available...
Key Points of CR8865

Splints, Casts, and Certain Intraocular Lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL" payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review MLN Matters® Article MM8645, “April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule” at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-Shelf (OTS) Orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

1. K0901- Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (uncentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and
2. K0902- Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (uncentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the “Medicare Claims Processing Manual,” Chapter 23, Section 60.3.1. at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Specific Coding and Pricing Issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of Change Request 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
Competitive Bidding
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2014


MLN Matters® Number: MM8676
Related Change Request (CR) #: CR 8676
Related CR Release Date: May 23, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2968CP
Implementation Date: October 6, 2014

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8676 to provide the DMEPOS Competitive Bidding Program (CBP) October 2014 quarterly update. CR 8676 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, the result being reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS conducted the supplier competition again in nine areas in 2009, referring to it as the Round One Rebid. The Round One Rebid contracts and prices became effective on January 1, 2011 in the nine areas.

MIPPA also delayed the competition for Round Two from 2009 to 2011 and authorized national mail order competitions after 2010. The Affordable Care Act of 2010 expanded the number of Round Two MSAs from 70 to 91 and specified that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies became effective on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expired on December 31, 2013. (The Round One Rebid mail-order diabetic supply contracts expired on December 31, 2012.) On January 1, 2014, new contracts for the Round One Recompete became effective in the same competitive bidding areas as the Round One Rebid.

Additional Information


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

NEW products from the Medicare Learning Network® (MLN)


2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs (http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD10-CM-and-GEMs.html) web page and 2015 ICD-10-PCS and GEMs (http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD10-PCS-and-GEMs.html) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

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REVISED products from the Medicare Learning Network® (MLN)


NEW product from the Medicare Learning Network® (MLN)


REVISED products from the Medicare Learning Network® (MLN)

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<td>PO Box 20010</td>
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<tr>
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<td>Nashville, TN 37202</td>
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<tr>
<td>Claim Reopenings (Adjustments)</td>
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<tr>
<td></td>
<td>Nashville, TN 37202</td>
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<tr>
<td></td>
<td>Fax (for underpayments): 1.615.782.4649</td>
</tr>
<tr>
<td></td>
<td>Fax (for overpayments): 1.615.782.4477</td>
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<tr>
<td>Claim Status Inquiry &amp; Beneficiary</td>
<td>Security Access Issues/Password Reset,</td>
</tr>
<tr>
<td>Eligibility</td>
<td>E-mail: <a href="mailto:CGS.Medicare.OPID@cgsadmin.com">CGS.Medicare.OPID@cgsadmin.com</a></td>
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<tr>
<td></td>
<td>Enrollment Status: 1.866.270.4909</td>
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<td>Appeals – Redetermination Requests</td>
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<td></td>
<td>PO Box 20009, Nashville, TN 37202</td>
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<tr>
<td></td>
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<tr>
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<tr>
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<td>DME MAC Jurisdiction C</td>
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<tr>
<td></td>
<td>PO Box 955152</td>
</tr>
<tr>
<td></td>
<td>St. Louis, MO 63195-5152</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Fax: 1.615.782.4647</td>
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<td>Supplier Enrollment</td>
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