Notice: CGS Administrators, LLC, Jurisdiction C Durable Medical Equipment Medicare Administrative Contractor (DME MAC), will provide a quarterly publication to all suppliers in the coverage area (Jurisdiction C includes: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia). The DME MAC Jurisdiction C Insider will contain important information that will assist the supplier community in day to day operations. It will include information published during the previous quarter by the Centers of Medicare and Medicaid Services (CMS) and by CGS.
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January 2014

“I Need Your Help!!!”

Everyone has seen the ForeSee® survey pop-up messages when you are buying things online or surfing the web. I’m asking that you take 2 minutes and click “Yes, I’ll Give Feedback” when you see the survey on CGSMedicare.com.

Why should you complete a survey? The more surveys we have per month, the more current the feedback information. Fewer survey results means CGS has to go back in time to collect the information. That results in out-of-date survey information that does not reflect your current feedback on our recent changes like the new web site re-design, the latest Medical Review tools and other helpful information contained on the site.

So here’s what I need: I would like each of you to encourage everyone who uses CGSMedicare.com to complete the survey as soon as possible. We need to increase survey participation so we know that we are providing you with the information, tools, and services that are important to you. Please be honest. What you think of the website is very important in giving us an accurate assessment of how we are doing. And while you’re at it, encourage everyone to set up a calendar reminder to complete a survey each month!

To learn how CGS uses your survey feedback, please watch “The Importance of ForeSee® Website Satisfaction Surveys” (http://www.cgsmedicare.com/jc/education/video/foresee.html) on the CGSMedicare.com website homepage. Our goal is superior customer service and the ForeSee® survey is just one way we can get the feedback from you, our customer, to make your experience interacting with CGS a positive one.

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director
DME MAC Jurisdiction C
Dear Physician:

The Comprehensive Error Rate Testing (CERT) Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), performs medical review audits for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries to determine the paid claims error rate for Medicare contractors and providers.

The CERT Contractor may request that your patient’s supplier obtain information from you in order to verify that Medicare coverage criteria have been met in dispensing the item(s) ordered by you. The supplier must submit the documentation to CERT within 30 days from the date of his/her receipt of the initial request letter. Failure to respond to the CERT’s request for documentation will result in an error and recoupment of the paid claim.

Medicare covers Enteral Nutrition under the Prosthetic Device Benefit as established by the Social Security Act §1862 (a)(8). Please refer to the Local Coverage Determination (LCD) on Enteral Nutrition, the related Policy Article and the Supplier Manual for additional information about coverage, billing and documentation requirements. You may access the Enteral Nutrition LCD on the CMS website under the Medicare Coverage Database.

Your patient’s medical record must contain sufficient information about his/her medical condition to substantiate that the applicable Medicare coverage criteria have been met. This information must justify the type of enteral nutrient ordered by you, how it is administered and the frequency of feedings. Also, as for all orders written by you for DMEPOS items for your Medicare patients, you are responsible for completing a detailed written order for each item. The detailed order requirements are also listed within the Enteral Nutrition LCD.

The most common CERT error related to clinical record documentation for Enteral Nutrition is the failure to show that the patient initially met the coverage criteria. Another frequent CERT error is the failure to establish the medical need for the patient to stay on Enteral Nutrition (“continued medical need”). To validate this, the supplier may use the physician’s clinical record showing that the physician made an indication of this within the preceding 12 months of the date of service being reviewed.

DMEPOS suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered for your patient if you do not provide information from your medical record when it is requested. Furthermore, if you do not provide this information to the supplier for this audit, your patient may have to pay for the item. Finally, your cooperation is a legal requirement as outlined in the Social Security Act which is the law governing Medicare.
Please do not send medical records that your supplier requests from you directly to the DME MAC, but rather return them to him or her. Also, please remember that you may not charge the supplier or the beneficiary to provide this information. Help your DMEPOS supplier continue to provide the highest quality of service to your patient by promptly providing the information from your medical record that is requested.

Sincerely,

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

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

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

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions
Robert D. Hoover, Jr., MD, MPH, FACP
Chief Medical Officer, DME MAC Jurisdiction C

Nebulizers - Coverage Criteria and Physician Documentation Requirements

Dear Physician:

Inhalation drugs are covered by Medicare Part B when the patient has a chronic pulmonary condition that will benefit from the use of inhalation therapy and they are administered using a durable medical equipment (DME) type of nebulizer (e.g., aerosol pneumatic compressor). Inhalation drugs administered using metered dose inhalers or similar devices are eligible for coverage by Medicare Part D but not the Medicare Part B DME benefit. The information in this letter addresses only those drugs administered using a DME nebulizer.

Inhalation drugs, nebulizers, and related accessories are covered for the following conditions:

- **Chronic Obstructive Pulmonary Disease (COPD):** Beta agonists (albuterol, arformoterol, formoterol, levalbuterol, metaproterenol), anti-cholinergics (ipratropium), corticosteroids (budesonide), and cromolyn.
- **Cystic Fibrosis:** Dornase alpha, tobramycin
- **Bronchiectasis:** Tobramycin, acetylcysteine
- **HIV, pneumocystis or complications of organ transplants:** Pentamidine
- **Pulmonary hypertension:** Iloprost, treprostinil
- **Thick/tenacious pulmonary secretions:** Acetylcysteine

*Medicare covers only FDA-approved formulations of inhalation drugs. Compounded inhalation solutions are not covered.*

Medicare also covers DME nebulizers and accessories when they are needed to provide humidification for patients with thick/tenacious secretions who have a diagnosis of cystic fibrosis or bronchiectasis or who have a tracheostomy or tracheobronchial stent.
The local coverage determination (LCD) on nebulizers identifies the usual maximum daily dose of inhalation drugs that is covered by Medicare. Of particular note is budesonide which is covered at a maximum dosage of 0.5 mg twice per day or 1.0 mg once per day. Refer to the LCD for information about the maximum covered quantities of other drugs or about the coverage of combinations of drugs in the same therapeutic class.

For most inhalation drugs, Medicare covers administration using standard aerosol pneumatic compressor-type nebulizers. Refer to the LCD for details on the coverage of specific nebulizers.

When you are initially ordering inhalation drugs, nebulizers, and accessories it is important that you clearly document in your medical records the patient’s diagnosis and other clinical information relating to their need for these items. Simply listing that information on the order or on a form provided by the supplier is not sufficient.

On an ongoing basis, when you see your patient for follow-up visits, it is important that you document the continued need for and use of inhalation drugs and nebulizers—just as you document the need for other medications that they are using.

There must be a detailed written order that lists the drug(s) with the dosage and frequency of administration, the nebulizer, and related accessories. This document may be prepared by the supplier, but you must review it, initial and date any changes, and then personally sign and date the order. Signature and date stamps are not acceptable. Verbal orders alone are not sufficient for Medicare coverage.

Physicians can view the complete local coverage determination and related policy article titled Nebulizers on the CGS Administrators, LLC web site at http://www.cgsmedicare.com. It may also be viewed in the local coverage section of the Medicare Coverage Database at http://www.cms.hhs.gov/mcd/search.asp.

Suppliers may ask you to provide the documentation from your medical records on a routine basis in order to assure that Medicare will pay for these drugs and that your patient will not be held financially liable. Providing this documentation is in compliance with the Health Insurance Portability and Accountability Act Privacy Rule. No specific authorization is required from your patient. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the inhalation drugs and nebulizers that are needed by your patient.

Sincerely,

Robert D. Hoover, Jr., MD, MPH, FACP
News from the Inside

Ordering/Referring Provider Alerts—Take Action!

Are you receiving warning messages on your claims saying the ordering/referring provider information is incorrect?

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

If so, you need to take action now to prevent these messages and future claim denials. CGS strongly encourages all suppliers to review the information available in MLN Matters Article SE1305 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf), particularly the edit explanation that begins on page 5 of the article.

**How to Prevent Ordering/Referring Provider Denials**

Before submitting a claim to the DME MAC, always check to be sure that the ordering/referring physician information on your claim is correct and that the physician is registered in Provider Enrollment, Chain, and Ownership System (PECOS) (https://pecos.cms.hhs.gov/pecos/login.do). When completing your claim, be sure to enter the ordering/referring physician’s name and NPI exactly as it appears in the PECOS records.

CGS and CMS offer several tools that allow you to easily check ordering/referring physician information. Use these tools to ensure that your claim will not receive unnecessary denials:

**myCGS**

The myCGS web portal (http://www.cgsmedicare.com/jc/mycgs/index.html) offers an easy way to check your ordering/referring physician information before you submit your claims. Simply log in to myCGS and follow these steps:

1. Go to the Claim Preparation tab
2. On the Claim Preparation tab, select the Ordering/Referring Physician secondary tab
3. Enter the physician’s NPI and the first six letters of the physician’s last name
4. Press the Submit button

myCGS will then display a message telling you whether or not the NPI and name are matching and a valid enrollment record is in PECOS.

If you are not familiar with myCGS, we encourage you to view our Benefits of myCGS (http://www.cgsmedicare.com/jc/mycgs/benefits.html) video.


**Jurisdiction C IVR**

The Jurisdiction C IVR (http://www.cgsmedicare.com/jc/cs/ivr.html) includes a feature that allows you to check ordering/referring physician information. Follow these steps:

1. Call the IVR at 866.238.9650
2. From the main menu, select option 1 for claim information, and then select option 5 for ordering/referring provider information
3. Enter the physician’s NPI and the physician’s last name using the letters on your telephone keypad

The IVR will then tell you whether or not the NPI and name are matching and a valid enrollment record is in PECOS.


**CMS Ordering Referring Report**

The Ordering Referring Report (http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/OrderingReferringFile-PDF.zip) is a file provided by CMS that contains the NPIs and names of physician and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The report is updated by CMS on a regular basis, so always make sure you are using the latest version of the file.

To access the report, go to the CMS Ordering & Referring Information webpage (http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html). The report is available in the “Downloads” section of the webpage.
myCGS

Learn How Easy It Is To Use myCGS! Watch Our Video Tutorials Today!

CGS provides you with step-by-step instructions on how to register for and access the many beneficial functions of the myCGS portal (http://www.cgsmedicare.com/jc/mycgs/index.html). The tutorials (http://www.cgsmedicare.com/jc/myCGS/tutorials.html) are divided into three easy-to-follow segments:

- Segment 1: Registration
- Segment 2: Eligibility, Claims, Claim Prep
- Segment 3: Finance, General Information

Each video segment includes actual screen shots so you can easily learn how to access the information you need with myCGS. Our video tutorials also make the registration process easy to understand and show you how easy it is to access eligibility, claim status, and claims payment information among others.

In additional to our myCGS video tutorials, we have also provided you with other helpful tools such as the complete myCGS Registration Guide (http://www.cgsmedicare.com/jc/myCGS/pdf/myCGS_RegistrationGuide.pdf), the myCGS User Manual (http://www.cgsmedicare.com/jc/myCGS/pdf/myCGS_UserManual.pdf), myCGS FAQs (http://www.cgsmedicare.com/jc/mycgs/faqs.html), and much more by visiting www.cgsmedicare.com (http://www.cgsmedicare.com).

See why more and more Jurisdiction C suppliers are using myCGS. Watch our video tutorials and register today!

Once on the CGS homepage, click on Medicare, click on DME MAC Jurisdiction C, and then click on the myCGS tab in the upper left hand corner of your screen.

Try myCGS today!

https://mycgswebportal.cms.gov/

© 2014 Copyright, CGS Administrators, LLC.
INFORMATION NEEDED:

HICN
Last Name
First Name
Date of Birth

INFORMATION AVAILABLE:

Part A Dates
Part B Dates
Deductible
Jurisdiction
MAP
MSP
Hospice
HHES
SNF/Hospital

INFORMATION NEEDED:

HICN
Last Name
First Name
Date of Service
RA Date*

INFORMATION AVAILABLE:

Claim Status
Explanation of Denial
Pending Claims
Order RA

INFORMATION NEEDED:

HICN
Last Name
First Name
HCPCS
Order/Refer NPI**
Order/Refer Name**
Date of Service/Year

INFORMATION AVAILABLE:

CMN Status
Ordering/Referring
Physician
Diabetic Supplies
Diabetic Shoes

REFERENCE GUIDE

* Applies to Order RA only
** Applies to Ordering/Referring Physician option only
*** Applies to Offsets only

Your NPI/PTAN is also needed but will automatically populate from your profile. If you wish to change to a different NPI/PTAN within your profile, click on the NPI or PTAN in the upper-right corner of myCGS and select the NPI/PTAN from the drop-down box.

Coverage & Billing

Billing Reminder: Nebulizers – Pharmacy Dispensing Fees for Inhalation Drugs

Recent reviews of Nebulizers and inhalation drugs have identified incorrect billing for inhalation drug dispensing fees. This article will review the billing requirements.

An initial dispensing fee (G0333) is payable to a pharmacy for the initial 30-day supply of covered inhalation drug(s) regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time. This initial 30-day dispensing fee is a once in a lifetime fee and only applies to beneficiaries who are using inhalation drugs for the first time as a Medicare beneficiary on or after 01/01/2006.

If code G0333 is billed for a 30-day supply of covered inhalation drugs and it is not the initial 30-day supply (i.e., G0333 has already been billed to Medicare for that beneficiary), the claim will be denied as incorrect coding.

When code G0333 has been billed once in a beneficiary’s lifetime, subsequent claims for a 30-day dispensing fee must be billed using code Q0513.

Medicare will only pay for one of the following for covered inhalation drugs regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time period—an initial dispensing fee (G0333), a 30-day dispensing fee (Q0513), or a 90-day dispensing fee (Q0514).

For a refill prescription, payment of a dispensing fee will be allowed no sooner than 7 days before the end of usage for the current 30-day or 90-day period for which a dispensing fee was previously paid. Medicare will not pay for more than 12 months of dispensing fees per beneficiary per 12-month period.

If the dispensing fee is billed sooner than the interval specified above, it will be denied as not separately payable. For example, if a 90-day fee (Q0514) is billed on 1/30/06 and is covered and there is a subsequent claim for a 30-day fee (Q0513) on 4/20/06, the dispensing fee on 4/20/06 will be denied as not separately payable.

Both a Q0513 and a Q0514 dispensing fee are not covered on the same date of service.

If a supplier dispenses a 90-day supply of one drug and a 30-day supply of another drug on the same day, code Q0514 (90-day fee) must be billed.

The dispensing fee must be billed on the same claim as the inhalation drug(s). If it is not, it will be denied as incorrect billing.

A dispensing fee is not separately billable or payable for saline, whether used as a diluent or for humidification therapy.

Medicare will not pay for a separate fee for the compounding of inhalation drug(s).

Refer to the Nebulizer LCD, related Policy Article and Supplier manual for additional information about coverage, billing and documentation requirements.

Documentation & Billing Reminders for Enteral Nutrition Claims

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have identified a growing trend in Comprehensive Error Rate Testing (CERT) errors for Enteral Nutrition related items. Suppliers are reminded of §1833(e) of the Social Security Act which precludes payment to any provider of services unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider.” It is expected that the beneficiary’s medical records will reflect the need for the care provided. The beneficiary’s medical records may include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be made available upon request from any auditing Medicare contractor.

Detailed Written Orders:

The detailed written order (DWO) for enteral nutrition is required prior to claim submission. The Medicare program allows for someone other than the ordering physician to create/produce the DWO. However the ordering physician must review the content of the DWO and sign and date it. The DWO must contain the following elements:

- Beneficiary’s name
- Physician’s name
Nutrients:

When the coverage criteria is met for the enteral nutrition therapy, the enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are deemed appropriate for the majority of beneficiaries requiring enteral nutrition.

If the patient exhibits intolerance to any semi-synthetic formula, the medical record must reflect the unfavorable events that resulted in the prescribing of the special enteral formula (B4149, B4153-B4155, B4157, B4161, and B4162). If a special enteral nutrition formula is provided and if the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary.

Continued Medical Need:

In addition to establishing the initial need for enteral nutrition, the clinical records may also be used to support continued medical need. Use of the clinical record to support continued medical need for the nutrients, supplies and equipment must be timely. Per the LCD requirements for continued medical need, the clinical documentation must be within the preceding 12 months of the date of service under review. Suppliers are not limited to the clinical record to support continued medical need and may use any of the following documents, in lieu of the clinical record to support that the items remain reasonable and necessary.

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified

Signature Requirements:

These guidelines apply not only to claims reviewed by the durable medical equipment Medicare administrative contractor (DME MAC), but also to claims reviewed by the Comprehensive Error Rate Testing (CERT) contractor, program safeguard contractor (PSC), and recovery audit contractor (RAC). For medical review purposes, Medicare requires that all orders and medical records that are used in the adjudication of claims be authenticated by the author. The method used must be a legible handwritten full signature, handwritten initials, or electronic signature. Those requirements are published in the CMS Internet-Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.1
Durable Medical Equipment Information Form (DIF):

Enteral nutrition is an item that requires a DIF. A valid DIF is one in which the supplier has attested to and signed supporting the medical need for the item. When the DME MACs, DME PSCs, and ZPICs identify a claim for which a DIF is not valid, they may deny the claim and/or initiate overpayment action. Suppliers are required to complete the DIF including their signature prior to claim submission. If the DIF is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category. Therefore, it is imperative that suppliers complete the DIF accurately to ensure that claims are adjudicated appropriately. For complete details concerning the completion of the DIF form, please consult the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, §5.3.

This article is only a summary of the Enteral Nutrition coverage and documentation requirements. Suppliers should read the entire Enteral Nutrition Local Coverage Determination and related Policy Article for additional coverage, coding and documentation requirements.

Walker Unbundling Billing for Brakes

The DME MACs have recently identified an unbundling issue related to walkers (E0141, E0143, and E0149) and brake attachments (E0159). This article provides clarification on when it is appropriate to bill the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) separately for walkers and brake attachments.

Upon initial issue of an E0141, E0143, and E0149, if brakes are being provided at the same time, the charges for these are included in the reimbursement for the walker and may not be billed separately to the DME MACs or the beneficiary. The following table can be found in the Walkers policy article; please note the status of E0159:

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

Note: HCPCS code E0159 (Brake attachment for wheeled walker, replacement each) is applicable for replacement brakes ONLY.

An advance beneficiary notice of noncoverage (ABN) should not be executed to shift financial liability to the beneficiary for brakes being provided at the time the walker is dispensed.

Refer to the Walkers LCD and related Policy Article for additional information about coverage, documentation and coding requirements.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. 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/.
Revision to the ViPS Medicare System Diagnosis Code Editing on the CMS-1500


MLN Matters® Number: MM8279
Related Change Request (CR) #: CR 8279
Related CR Release Date: August 5, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2756CP
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

Additional Information


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

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: October 30, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2805CP
Implementation Date: January 6, 2014
Provider Types Affected

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

Provider Action Needed

This article is based on 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


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

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

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

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

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REFO1=P4) when a clinical trial claim includes:

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

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

- Claim Adjustment Reason Code (CARC) 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT).”
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**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).**

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**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.

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**Additional Information**


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

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**Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131**


**MLN Matters® Number:** MM8404  
**Related Change Request (CR) #:** CR 8404  
**Related CR Release Date:** September 6, 2013  
**Effective Date:** December 9, 2013  
**Related CR Transmittal #:** R2782CP  
**Implementation Date:** December 9, 2013

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**Note:** This article was revised on October 22, 2013, to add a link to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8403.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8403.pdf) that alerts HH providers that effective December 9, 2013, HHABN Form CMS-R-296 will be discontinued and HHCCN will replace the HHABN option boxes 2 and 3. HHABN option box 1 will be replaced by the ABN of Noncoverage (CMS-R-131). All information is unchanged.

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**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 8404 which provides: 1) instructions for Home Health Agency (HHA) use of the Advance Beneficiary Notice of Noncoverage (ABN) to replace the outgoing Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1; 2) ABN issuance guidelines for therapy services and therapy specific examples; and 3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

Home health agencies and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes. All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf)) for general ABN information.

**Background**

Section 1879 of the Social Security Act (the Act) protects Fee-For-Service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when Limitation of Liability (LOL) applies.

The Centers for Medicare & Medicaid Services (CMS) is expanding use of the ABN to include issuance by home health agency (HHA) providers for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 that is currently used by HHAs. The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at [http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html](http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html) on the CMS website. The guidelines for ABN use published in Chapter 30, Section 50 of
the “Medicare Claims Processing Manual” and the ABN form instructions apply to HHAs unless otherwise noted.

**Key Points from the Updated Chapter 30 Section 50**

**HHA Use of ABN – General Use**

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where “Limitation on Liability” (LOL) protection is afforded under Section 1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL projections. HHAs should contact their RHHI if they have questions on the ABN or related instructions, since RHHIs process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes.

### Table 1

<table>
<thead>
<tr>
<th>Application of LOL for the Home Health Benefit Citation from the Act</th>
<th>Brief Description of Situation</th>
<th>Recommended Explanation for “Reason Medicare May Not Pay” section of ABN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1862(a)(1)(A)</td>
<td>Care is not reasonable and necessary</td>
<td>Medicare does not pay for care that is not medically reasonable and necessary.</td>
</tr>
<tr>
<td>Section 1862(a)(9)</td>
<td>Custodial care is the only care delivered</td>
<td>Medicare does not usually pay for custodial care, except for some hospice services.</td>
</tr>
<tr>
<td>Section 1879(g)(1)(A)</td>
<td>Beneficiary is not homebound</td>
<td>Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit</td>
</tr>
<tr>
<td>Section 1879(g)(1)(B)</td>
<td>Beneficiary does not need skilled nursing care on an intermittent basis</td>
<td>Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit</td>
</tr>
</tbody>
</table>

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility. In addition, when Medicare considers an item or service experimental (e.g., a “Research Use Only” or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

**HHA Triggering Events**

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Table 2, below, outlines triggering events specific to HHAs.

### Table 2

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation</td>
<td>When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.</td>
</tr>
<tr>
<td>Reduction</td>
<td>When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.</td>
</tr>
<tr>
<td>Termination</td>
<td>When an HHA expects that Medicare coverage will end for all items and services in total.</td>
</tr>
</tbody>
</table>

*ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in this Table. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.

- **HHA Initiations**
  The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:
    - The care is not medically reasonable and necessary;
    - The beneficiary is not confined to his/her home (is not considered homebound);
    - The beneficiary does not need skilled nursing care on an intermittent basis; or
    - The beneficiary is receiving custodial care only.
Note: If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

INITIATION EXAMPLE: A beneficiary requires skilled nursing wound care 3 times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-covered care, and to accept the financial obligation.

An ABN, signed at initiation of home health care for items and/or services not covered by Medicare, is effective for up to a year; as long as the items/services being given remain unchanged from those listed on the notice.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events, and is subject to ABN issuance requirements if applicable. When an HHA performs a beneficiary’s initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions in which a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency cannot issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

HHA Reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the Plan of Care (POC). If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the item or service and will assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services. (Technically, this is an initiation of noncovered services following a reduction of services).

REDUCTION WITH SUBSEQUENT INITIATION EXAMPLE: A beneficiary requires Physical Therapy (PT) for gait retraining 5 times per week for 2 weeks, then reduce to 3 times weekly for 2 weeks. After 2 weeks of PT, the beneficiary wants to continue therapy 5 times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

HHA Terminations

A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services; the HHA must issue the beneficiary an ABN in order to charge the beneficiary or a secondary insurer. If the beneficiary will not be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for “FFS ED Notices” at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on the CMS website.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of noncovered care.

Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.
Some States have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare noncovered care that Medicaid will cover. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the “payer of last resort” (meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid assumes any remaining charges).

On the ABN, the first check box under the “Options” section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

**Note:** If a State has issued a directive to select the third checkbox on the HHABN, HHAs must mark the first check box when issuing the ABN.

Where there is no State specific directive, HHAs are permitted to instruct beneficiaries to select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the “Additional Information” section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care to your other insurance,” or “Your Medical Assistance plan will pay for this care.”

HHAs may also use the “Additional Information” on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the “Additional Information” section of the notice.

**HHA Exceptions to ABN Notification Requirements**

ABN issuance is NOT required in the following HHA situations:

- Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);
- Telehealth monitoring used as an adjunct to regular covered HH care; or
- Noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH Prospective Payment System (PPS) episode payment).

**Other HHA ABN Guidance**

1. **ABN for Voluntary Notice by HHAs**

   HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the “Medicare Claims Processing Manual,” Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

2. **Effect of Initial Payment Determinations on Liability**

   An ABN informs a beneficiary of his/her HHA’s expectation with regard to Medicare coverage. If the care described on the ABN is actually provided, Medicare makes a payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider’s expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider’s expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA’s expectation, or deny the claim and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

3. **Use of abbreviations**

   When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as “PT” that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

4. **Cost Estimate**

   HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed on the ABN.
Cost Estimate Examples:

- $440 for 4 weekly nursing visits in 1/13.
- $260 for 3 physical therapy visits 1/3-1/7/13.
- $50 for spare right arm splint.

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

Outpatient Therapy Services Use of the ABN

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don’t qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn’t required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn’t applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn’t pay. If the ABN isn’t issued when it is required and Medicare doesn’t pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because the services are not medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

THERAPY CAP IS NOT MET - ABN MANDATORY EXAMPLE: A beneficiary has been receiving Physical Therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the Plan of Care (POC). The total amount applied to his therapy cap this year is $780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

THERAPY CAP HAS BEEN MET - ABN MANDATORY EXAMPLE: A beneficiary has recently been receiving Physical Therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Additional Information

The official instruction, CR8404, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf on the CMS website. The revised portions of the “Medicare Claims Processing Manual” are a part of CR8404.

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

LCD and Policy Article Revisions
Summary for August 29, 2013

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

Manual Wheelchair Bases

LCD
Revision Effective Date: 10/01/2013

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
- Added: K0008
- Added: E1037 – E1039 and K0008 coverage criteria

HCPCS CODES:
- Added: E1037 – E1039 and K0008

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

Policy Article
Revision Effective Date: 10/01/2013

CODING GUIDELINES:
- Added: K0008 description and reference
- Removed: K0108 billing method for wheelchair modification

Oral Antiemetic Drugs
(Replacement for Intravenous Antiemetics)

LCD
Revision Effective Date: 05/29/2013 (August 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
- Added: Coverage for use with alemtuzumab, azacitidine, bendamustine, carboplatin, clofarabine, cytarabine, daunorubicin, idarubicin, ifosfamide, irinotecan and oxaliplatin

HCPCS CODES:
- Added: GA and GZ modifiers

DOCUMENTATION REQUIREMENTS:
- Added: Instructions for GA and GZ modifiers when R&N criteria are not met

Policy Article
Revision Effective Date: 12/15/2013

Urological Supplies

LCD
Revision Effective Date: 12/15/2013

HCPCS CODES:
- Added: GA and GZ modifiers

DOCUMENTATION REQUIREMENTS:
- Added: Instructions for GA and GZ modifiers when R&N criteria are not met

Policy Article
Revision Effective Date: 12/15/2013

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 at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A webinar will be available soon to enhance your understanding.
CODING GUIDELINES:
- Revised: A4353 definition to include sterile “no-touch” catheter systems

Note: The information contained in this article is only a summary of revisions to LCD and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A webinar will be available soon to enhance your understanding.

LCD and Policy Article Revision Summary for November 15, 2013

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

Nebulizers

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

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

Note: The information contained in this article is only a summary of revisions to LCD and Policy Article. For complete information on any topic, you must review the Nebulizer LCD (http://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=http%3a%2f%2fwww.cms.gov%2fmedicare-coverage-database%2findexes%2fclid-list.aspx%3fCntrctr%3d140%26name%3dCGS+Administrators%2c+LLC+(18003%2c+DME+MAC)%26DocType%3dActive%26Contr%26ContrId%3d140%26ICon%3d0%26LCntrctr%3d140%26bc%3dAgACAIAAAAAAA%3d%3d%26&page=medicare-coverage-database/details/lcd-details.aspx&LCDId=5007&ContrId=140&ver=99&ContrVer=2&ContrSelected=140&ContrId=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140%26bc=AgACAIAAAAAAA%3d%3d%3d%3d) and/or Nebulizer Policy Article (http://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=http%3a%2f%2fwww.cms.gov%2fmedicare-coverage-database%2findexes%2fclid-list.aspx%3fCntrctr%3d140%26name%3dCGS+Administrators%2c+LLC+(18003%2c+DME+MAC)%26DocType%3dActive%26Contr%26ContrId%3d140%26ICon%3d0%26LCntrctr%3d140%26bc=AgABAAEAAAAAA%3d%3d%3d%3d).

Power Mobility Devices Local Coverage Determination – Update

The Power Mobility Devices Local Coverage Determination (LCD) has been revised to restore the original prescription requirements.

This clarification has been incorporated with the current policy effective for dates of service on or after October 1, 2013.

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

Display of ICD-10 Local Coverage Determinations (LCDs) on the Medicare Coverage Database (MCD)


MLN Matters® Number: MM8348
Related Change Request (CR) #: CR8348
Related CR Release Date: September 6, 2013
Effective Date: October 7, 2013
Related CR Transmittal #: R1293OTN
Implementation Date: April 10, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8348 which is issued by the Centers for Medicare & Medicaid Services (CMS) to ensure that International Classification of Diseases, Tenth Revision (ICD-10) LCDs and articles are published in the Medicare Coverage Database (MCD) in a timely manner to allow providers sufficient time to make provider specific billing
system changes. Make sure that your billing staff is aware of these changes.

Background

CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the Medicare Coverage Database (MCD) no later than April 10, 2014. All other LCDs and articles (i.e., those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014.

Note: All LCDs and Articles will receive a new LCD/Article ID number. For example, LCD ID 1234 might become LCD ID 4567.

The new LCD/Article ID number could have an impact on MACs local systems, such as changing their Medicare Summary Notice to capture the new LCD/Article ID number.

CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies will not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public comment and notice process.

However, if a MAC decides to revise more than just the ICD-10 code(s), they will follow the normal LCD development process outlined in the “Medicare Program Integrity Manual” (Publication 100-08, Chapter 13 (Local Coverage Determinations)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf on the CMS website.

Additional Information


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

Additional States Requiring Payment Edits for DMEPOS Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics. Update to CR 3959


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

Provider Types Affected

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

Provider Action Needed

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

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

**Background**

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


**Additional Information**


If you have any questions, please contact your DME MACs at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/monitoring-programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/monitoring-programs/provider-compliance-interactive-map/index.html) on the CMS website.

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**Appeals**

**Reminder - Appeals Requests**

Recently CGS’ Medical Director, Dr. Robert Hoover, has received a number of requests for “LCD Reconsiderations” via fax. Upon further examination, the requests are not for LCD reconsiderations but rather requests for a claim redetermination (1st level of appeal). There is an important difference!!! Because there are strict guidelines from the Centers for Medicare & Medicaid Services (CMS) for timeliness of claim reconsideration requests, misrouted requests can result in delayed appeals decisions.

Suppliers who wish to appeal a claim determination must file a timely Redetermination Request. The Appeals staff at CGS handle requests for redeterminations. Information about requesting a redetermination can be found on the CGS web site at [http://www.cgsmedicare.com/jc/claims/appeals/index.html](http://www.cgsmedicare.com/jc/claims/appeals/index.html). In addition, this site has a Redeterminations Request Form that may be used to fax requests for redeterminations to CGS. The fax number is **615-782-4630**.

Requests for a claim redetermination are different from an LCD Reconsideration request. The LCD (Local Coverage Determination) Reconsideration process is a method by which interested parties can request a revision to an active LCD. It is not the process by which an individual claim (or group of claims) is appealed. Information about LCD Reconsiderations is available on the CGS web site at [http://www.cgsmedicare.com/jc/pubs/news/2008/0708/cope7961.html](http://www.cgsmedicare.com/jc/pubs/news/2008/0708/cope7961.html). Requests for LCD Reconsideration, along with the required supporting documentation and clinical literature, may be faxed to Dr. Hoover at **615-664-5955**.

Suppliers are encouraged to check the information on their Redetermination Requests and send the appeal (either via fax or mail) to the correct recipient to avoid delays in claim decisions.
Redetermination Tips for Fax Transmissions

CGS accepts faxed Redetermination requests, among many other requests. To ensure that your faxed request is processed accurately and quickly, we have provided you with some important tips:

- If you are sending multiple requests in one fax transmission, use the Separator Sheet (http://www.cgsmedicare.com/jc/forms/pdf/JC_separator_sheet.pdf). The printable sheet is located under the forms section on http://www.CGSmedicare.com. The separator sheet helps us electronically keep your fax transmissions separate.
- Make sure CGS is the intended recipient of your fax. Often times, CGS receives Redetermination requests that are actually intended for another jurisdiction.
- Keep your documents clear and legible otherwise, our electronic systems may not be able to read them.
- Keep everything together. Include all documents needed to support your request.
- Be sure to use the correct fax number. The fax number for Jurisdiction C, DME MAC, Redeterminations is 1-615-782-4630. The fax number is also printed on the bottom of our Redetermination Request form.

CGS is Seeing a High Number of Duplicate Redetermination Requests

Verify Redetermination Request Status before Filing Duplicate Redetermination Requests

Before you file a duplicate redetermination request, you should check the status of the original request.

CGS is seeing a high number of duplicate redetermination requests. Filing duplicate redetermination requests can significantly increase processing time, as all requests are completed on a first in, first out basis and receive a complete redetermination review.

The time limit for requesting a redetermination is 120 days from the date of issuance of the remittance notice or the date of the overpayment demand letter. The DME MAC redetermination staff will determine if the request was filed timely or if good cause was established for a request not filed timely. The DME MAC redetermination staff has 60 days to complete a redetermination.

You Can Check the Status of Your Redetermination Using the myCGS Web Portal or the Interactive Voice Response (IVR) unit

myCGS is your best option for checking the status of your Redetermination. Once you have logged into myCGS, click on the Redetermination tab, click either the DCN or CCN radio button, and enter the following information:

- DCN or CCN (as appropriate) and the
- HICN of the beneficiary on the claim which you have appealed
- Then click submit

myCGS will return following information about your request:

- Date in which your request was received and the
- Status of your request

If you wish to perform another redetermination search, all you have to do is click on the New Search button.

If you are not familiar with myCGS, we encourage you to watch the “Benefits of myCGS” (http://www.cgsmedicare.com/jc/mycgs/benefits.html) video. This brief program includes highlights of myCGS functionality and provides information on the services available.

Information is also available by IVR at 866.238.9650. From the IVR main menu,

- select option 1 (claim information),
- followed by option 3 (redetermination information),
- and then option 2 (redetermination status).

To verify redetermination statuses, you must provide your NPI, PTAN, last five digits of your tax identification number (TIN), the beneficiary’s Medicare number, beneficiary’s name, and either CCN or ICN of the claim that is being appealed. The IVR will provide the status of your redetermination request, including whether it is pending, reversed, upheld, or dismissed. You may also request a copy of the redetermination decision letter (if the redetermination request has been completed). For additional information on navigating the IVR, refer to the IVR system script (http://www.cgsmedicare.com/jc/help/ivr.html) and the IVR User Guide (http://www.cgsmedicare.com/jc/help/pdf/DME_IVR_checklist.pdf) available on our website at CGSmedicare.com.
Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs)


MLN Matters® Number: MM8268
Related Change Request (CR) #: CR 8268
Related CR Release Date: September 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1296OTN
Implementation Date: January 6, 2014

Note: This article was revised on September 27, 2013, to reflect the release of a new Change Request (CR), dated September 25, 2013. The revised CR instructs contractors not auto-populate the HICNs on reconsideration request forms. The transmittal number, CR release date and web address for the CR also changed. 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, Home Health and Hospice Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs, and A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

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

Background

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

Additional Information


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

Miscellaneous

Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice


MLN Matters® Number: MM8182
Related Change Request (CR) #: CR 8182
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1291OTN
Implementation Date: October 7, 2013, except January 6, 2014 for claims processed by DME MACs
Note: This article was revised on September 16, 2013, to add a reference to MM8365 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf) for business scenarios, descriptions and updates related to Rule 3 of the Operating Rule Set – CORE-defined Claim Adjustment and Denials to become effective January 1, 2014. All other information remains the same.

Provider Types Affected

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

What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at http://aspe.hhs.gov/admnsimp/pl104191.htm#1173 on the internet.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and “disappointing.” (You can find a copy of this testimony at http://www.ncvhs.hhs.gov/ on the internet.)

The EFT & ERA Operating Rule Set includes the following rules: (Please note that CR 8182 focuses only on rule numbers 3 and 4)

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

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

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

Business Scenarios

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

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment
for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

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

**Scenario #2 - Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim**
This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

**Scenario #3 - Billed Service Not Covered by Health Plan**
This scenario refers to situations in which the billed service is not covered by the health plan.

**Scenario #4 - Benefit for Billed Service Not Separately Payable**
This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

**Additional Information**


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


**MLN Matters® Number:** MM8347  
**Related Change Request (CR) #:** CR 8347  
**Related CR Release Date:** August 2, 2013  
**Effective Date:** September 3, 2013  
**Related CR Transmittal #:** R224FM  
**Implementation Date:** September 3, 2013

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

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

Key Points

The following points are based on the revised manual, “Medicare Financial Management,” Chapter 4—Debt Collection.

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

Additional Information


You may review CR7688 for an explanation of the policy that implements a standard “immediate recoupment” process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf) on the CMS website.

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


**MLN Matters® Number:** MM8365

**Related Change Request (CR) #:** CR 8365

**Related CR Release Date:** August 16, 2013

**Effective Date:** January 1, 2014

**Related CR Transmittal #:** R1281OTN

**Implementation Date:** January 6, 2014

**Provider Types Affected**

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

**Provider Action Needed**

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


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

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

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

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

Business Scenarios

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

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

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

Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3: Billed Service Not Covered by Health Plan

Refers to situations where the billed service is not covered by the health plan.

Scenario #4: Benefit for Billed Service Not Separately Payable

Refers to situations where the billed service or benefit is not separately payable by the health plan.

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


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

New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Payment Due to Sequestration


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

Note: This article was revised on September 5, 2013, to revise the title to be consistent with the Change Request. All other information is unchanged

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

● 253 - Sequestration - Reduction in Federal Spending

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

Additional Information


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

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


MLN Matters® Number: MM8391 Revised
Related Change Request (CR) #: CR 8391
Related CR Release Date: August 16, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1285OTN
Implementation Date: October 7, 2013, except January 6, 2014 for DME MACs
Provider Types Affected

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

What You Need to Know

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

Additional Information


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

Healthcare Provider Taxonomy Codes (HPTC) Update, October 2013


MLN Matters® Number: MM8417
Related Change Request (CR) #: CR 8417

Related CR Release Date: August 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2762
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need To Know

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

Background

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

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

They state that this information is:

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

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

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

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

Additional Information


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

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update


MLN Matters® Number: MM8422
Related Change Request (CR) #: CR 8422
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2776CP
Implementation Date: October 7, 2013

Provider Types Affected

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

What You Need To Know

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

Background

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

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

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

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 262686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.
Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR8281

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

### New Codes – CARC:

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

### Modified Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>18</td>
<td>Exact duplicate claim/service (Use only with Group Code OA except where state workers’ compensation regulations require CO)</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>45</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)</td>
<td>07/01/2013</td>
</tr>
<tr>
<td>136</td>
<td>Failure to follow prior payer’s coverage rules. (Use only with Group Code OA)</td>
<td>07/01/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>163</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>164</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>173</td>
<td>07/01/2013</td>
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<td>209</td>
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<td>226</td>
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<td>236</td>
<td>07/01/2013</td>
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<tr>
<td>238</td>
<td>07/01/2013</td>
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<tr>
<td>242</td>
<td>06/02/2013</td>
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<tr>
<td>243</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>250</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>251</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>252</td>
<td>06/02/2013</td>
</tr>
<tr>
<td>W1</td>
<td>06/02/2013</td>
</tr>
</tbody>
</table>
W2 Payment reduced or denied based on workers’ compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier ‘IG’) if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF) if the regulations apply. To be used for Workers’ Compensation only.

06/02/2013

Y1 Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier ‘IG’) if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF) if the regulations apply. To be used for P&C Auto only.

06/02/2013

Y2 Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier ‘IG’) if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF) if the regulations apply. To be used for P&C Auto only.

06/02/2013

Y3 Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF) if the regulations apply. To be used for P&C Auto only.

06/02/2013

Changes in RARC List Since CR8281

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

© 2014 Copyright, CGS Administrators, LLC.
The services billed are considered Covered or Non-Covered (NC) in the applicable state fee schedule.

Reimbursement has been made according to the bilateral procedure rule.

Mark-up allowance

Reimbursement has been adjusted based on the guidelines for an assistant.

Adjusted based on diagnosis-related group (DRG).

Adjusted based on Stop Loss.

Payment based on invoice.

This policy was not in effect for this date of loss. No coverage is available.

No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.

The date of service is before the date of loss.

The date of injury does not match the reported date of loss.

Adjusted based on achievement of maximum medical improvement (MMI).

Payment based on provider’s geographic region.

An interest payment is being made because benefits are being paid outside the statutory requirement.

This should be billed with the appropriate code for these services.

The billed service(s) are not considered medical expenses.

This item is exempt from sales tax.

Sales tax has been included in the reimbursement.

Documentation does not support that the services rendered were medically necessary.

Alert: Consideration of payment will be made upon receipt of a final bill.

Adjusted based on an agreed amount.

Adjusted based on a legal settlement.

Services by an unlicensed provider are not reimbursable.

Only one evaluation and management code at this service level is covered during the course of care.

Missing prescription

Incomplete/invalid prescription

Adjusted based on the Medicare fee schedule.

This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.

Payment based on a jurisdiction cost-charge ratio.

Alert: Amount applied to Health Insurance Offset.

Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.

Not covered unless a pre-requisite procedure/service has been provided.

Additional information is required from the injured party.

Service does not qualify for payment under the Outpatient Facility Fee Schedule.

Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.

Alert: Processing of this claim/service has included consideration under Major Medical provisions.

Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.

This missed/cancelled appointment is not covered.

Additional Information

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

Claim Status Category and Claim Status Codes Update


MLN Matters® Number: MM8446
Related Change Request (CR) #: CR 8446
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2792CP
Implementation Date: January 6, 2014

Provider Types Affected

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

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8446, from which this article is taken, and requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

All code changes approved during the September 2013 committee meeting will be posted on or about November 1, 2013 at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ and are reflected in the X12 277 transactions issued on and after the date of implementation of this CR8446 (January 1, 2014).

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the X12 276/277 Health Care Claim Status Request and Response format.

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR8446 (January 1, 2014), your Medicare contractor will:

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes; and
3. Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional Information

The official instruction, CR 8446 issued to your MAC regarding this change may be viewed at http://cms.gov/Regulations-and-


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

Medicare Remit Easy Print (MREP) Annual Enhancement Status Codes Update


MLN Matters® Number: MM8467
Related Change Request (CR) #: CR 8467
Related CR Release Date: September 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2795CP
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8467 which informs Medicare contractors about the following annual changes to the Medicare Remit Easy Print (MREP) software. Those changes are:

- Revise the MREP remittance advice layout to remove the blank line after each set of Claim Line details and
- Revise the MREP remittance advice layout by adding the Claim Adjustment Reason Code (CARC) Adjustment Amount (CARC-AMT) to the fields subtotalted for each claim.

Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS)
developed the MREP software to help providers to transition from paper to electronic format of the remittance advice. The Electronic Remittance Advice (ERA) must be the standard format adopted under the Health Insurance Accountability and Portability Act (HIPAA). Currently the HIPAA adopted standard is the ASC X12 Transaction 835 version 005010A1. MREP users can view and print the ERA in humanly readable format and can send a hard copy remittance advice with their claims to payers after Medicare. Additionally, MREP users can run and download a number of special reports that have been added in response to enhancement requests from users. This software is available for free and has been updated on a yearly basis since its introduction in October 2005. CR8467 is instructing VIPs - the software developer - to update MREP based on requests received from users through the MACs and/or the CMS website.

Additional Information


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

Mobile Apps for the OPEN PAYMENTS program (Physician Payments Sunshine Act)


**MLN Matters® Number**: SE1329  
**Related Change Request (CR) #**: Not Applicable (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 Article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Home Health and Hospice Medicare Administrative Contractors (HH&H MACs), Durable Medical Equipment MACs (DME MACs), and A/B MACs) for services to Medicare beneficiaries.

**What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) announced July 17, 2013, the availability of two new mobile applications (mobile apps) for the OPEN PAYMENTS program (Physician Payments Sunshine Act), which are designed to assist in helping physicians, applicable manufacturers, and applicable Group Purchasing Organizations (GPOs) track much of the data necessary for successful program reporting. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

The two new mobile apps track contact information of physicians and industry, share information between the physician and industry apps using mobile technology, and track payments and other transfers of value in real-time.

One app is targeted specifically to physicians (OPEN PAYMENTS Mobile for Physicians) and the other is for industry, including applicable manufacturers and applicable GPOs (OPEN PAYMENTS Mobile for Industry). A picture of the app icons is shown below.

<image of app icons>

Ultimately, the goal of these apps is to make tracking payment information easier and more convenient, and to improve the accuracy of payment information by tracking payments as they occur throughout the year.

You and your staff should read more information about the apps in the Background section below.

**Additional Information**

Background

Why are these apps needed?

The new OPEN PAYMENTS mobile applications will assist physicians and the industry in tracking financial relationships. The two free mobile apps will help physicians and health care industry users to track their payments and other financial transfers that the industry will report under the OPEN PAYMENTS program (Physician Payments Sunshine Act). Created by a provision of the Affordable Care Act, OPEN PAYMENTS creates greater public transparency about the financial transactions between doctors, teaching hospitals, drug and device manufacturers, and other health care businesses.

CMS has made these apps available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the OPEN PAYMENTS website. CMS’s goal is about providing user-friendly tools for doctors, manufacturers, and others in the health care industry to use in working with CMS to implement the law in a smart way. These two apps are innovative options for doctors and the industry to accurately and securely track their financial ties and other transfers of values as required under this important transparency program.

To support the “OPEN PAYMENTS” program, CMS designed the mobile applications (one each for physicians and health care industry users), merging this proven and efficient format with real-time 24-hour tracking technology. The apps offer on-the-go convenience for users to track financial data. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

What are the reporting requirements of OPEN PAYMENTS?

August 2013 marked the beginning of pharmaceutical and device manufacturers and Group Purchasing Organizations (GPOs) collecting and preparing to report payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership and investment interests, as required by the OPEN PAYMENTS program.

Physicians are not required to report any information to CMS, though they may wish to use this app to help validate reports submitted by manufacturers to CMS about payments they have received. (Reporting requirements do not apply to physician claims payments.)

Financial information entered into the apps will help health care industry entities meet the timely reporting requirements of the OPEN PAYMENTS program. Financial data loaded into the apps does not interact with CMS systems and cannot be used for direct data reporting to CMS or its contractors. In addition, CMS will not validate the accuracy of data stored in the apps, nor will it be responsible for protecting data stored in the apps.

For physician users, the OPEN PAYMENTS Mobile for Physicians mobile app will help them assure that industry information reported about them is accurate by:

- Tracking payments and other transfers of value received from their health care industry affiliations in real-time, as they occur;
- Transferring user profile and high level information associated with the event or situation in which the “transfer of value” occurred between physicians and industry; and
- Storing personal contact information.

Industry app users hold the responsibility for accuracy and completeness of their official reports. For industry users, the OPEN PAYMENTS Mobile for Industry mobile app will facilitate their reporting by:

- Tracking their payments and other transfers of value assigned to physicians and teaching hospitals, in real-time;
- Transferring user profile and high level information associated with the event or situation in which the “transfer of value” occurred between physicians and industry;
- Helping to ensure greater accuracy of information about financial relationships with physicians; and
- Collecting physician user profile information.

What is a mobile app?

A mobile application (or mobile app) is a software application designed to run on smartphones and other mobile devices.

Is use of the apps completely voluntary?

The use of the apps is voluntary. The apps are available for the user’s own information collection and to serve as a personal storage depository only.
How can I obtain the mobile apps?

You can download the mobile apps directly from your app store (e.g., iOS Apple™ or GooglePlay™); search for either OPEN PAYMENTS Mobile for Physicians or OPEN PAYMENTS Mobile for Industry, depending on which app you are downloading and follow your normal downloading instructions.

What if I have questions about the functions and uses of the apps?


You can also view a demonstration of the app during the upcoming National Provider Call on August 8, 2013. To register, visit MLN Connects Upcoming Calls at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html on the CMS website.

For help with the apps you can contact the OPEN PAYMENTS helpdesk at openpayments@cms.hhs.gov. Please also send any comments or suggestions regarding the apps’ functionality to our help desk, as we are continuing to explore opportunities to leverage technology solutions that will help enable successful program implementation.

Keep up with Provider Outreach and Education on Facebook and Twitter!!

Check out the DME MAC POE team on Facebook at http://www.facebook.com/CGSadminDME.

Become a fan and get up-to-date information about POE, CGS, and CMS.

Find Provider Outreach and Education on Twitter by searching “@CGSDMEPOE” on your Twitter account. Provider Outreach events and helpful tips can be found in our tweets!

Did you know that Provider Outreach has a website site page?

Go to http://www.cgsmedicare.com/jc and click on “Education” in the navigation buttons on the left. Click the…

- Calendar of Events (http://www.cgsmedicare.com/medicare_dynamic/wrkshp/DME_COE/DME_Report.asp) for dates and times for our webinars, workshops and state association engagements.
- ACT (Ask the Contractor Teleconference) (http://www.cmsmedicare.com/jc/education/act.html) for transcripts of past ACT calls.
- Online Education Center (http://www.cmsmedicare.com/medicare_dynamic/education/001.asp) for a variety of topics covering everything from Medicare basics to lesser-known policies such as Eye Prostheses. We continue to add courses, so check back often.
- Workinars (http://www.cgsmedicare.com/jc/education/workinars.html) to register for our scheduled webinars. Provider Outreach conducts up to 20 webinars per month. These webinars are a wonderful way to keep current on policy changes and get your questions answered at the same time!
- Workshops and Seminars (http://www.cgsmedicare.com/jc/education/workshops.html) to register for one of our live events. POE representatives travel across Jurisdiction C throughout the year. Find out when Provider Outreach is coming to a city near you and get signed up!

Fees & Pricing

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


MLN Matters® Number: MM8448
Related Change Request (CR) #: CR 8448
Related CR Release Date: September 6, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2780CP
Implementation Date: January 6, 2014
Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8448 which instructs Medicare contractors to download and implement the January 2014 Average Sales Price (ASP) drug pricing files; and, if released by the Centers for Medicare & Medicaid Services (CMS), the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and Not Other 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 January 1, 2014, with dates of service January 1, 2014, through March 31, 2014; and
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

You should make sure that your billing staffs are aware of these changes.

Background

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

The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS); who will quarterly supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. 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 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER). You can find this manual 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>
</tr>
</thead>
<tbody>
<tr>
<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>
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<td>April 2013 ASP and ASP NOC</td>
<td>April 1, 2013, through June 30, 2013</td>
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<td>January 2013 ASP and ASP NOC</td>
<td>January 1, 2013, through March 31, 2013</td>
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Please note that: 1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106% ASP, 106% Wholesale Acquisition Cost (WAC), or 95% Actual Wholesale Price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations;

2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Section 20.1.3 (Exceptions to Average Sales Price (ASP) Payment Methodology); which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf on the CMS website; and 3) Your MAC will seek payment allowances from their local carrier for drugs and biologicals that are not on the ASP file.

In addition, you should be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information


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

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2013 Update


MLN Matters® Number: MM8286
Related Change Request (CR) #: CR 8286
Related CR Release Date: May 2, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2695CP
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8286 which informs Medicare contractors about the updating of specific drug and biological HCPCS codes which occurs quarterly. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Key Points of CR8286

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will no longer be payable for Medicare:

- J3487: Injection, Zoledronic Acid (Zometa), 1mg.
- J3488: Injection, Zoledronic Acid (Reclast), 1mg.
- J9002: Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will be payable for Medicare:

- Q2033: Influenza Vaccine, Recombinant Hemagglutinin Antigens, For Intramuscular Use (Flublok).
- Q2050: Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg.
- Q2051: Injection, Zoledronic Acid, not otherwise specified, 1mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS code will be accepted on claims, but not payable by Medicare:

- Q0090: Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg.

Additional Information


If you have any questions, please contact your FI, carrier, RHHI, DME/MAC, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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Go to: http://www.cgsmedicare.com/Medicare.html
Click “Join the ListServ”
Competitive Bidding

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2014


MLN Matters® Number: MM8434
Related Change Request (CR) #: CR 8434
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2793CP
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8434 to provide the DMEPOS Competitive Bidding Program (CBP) January 2014 quarterly update. Change Request (CR) 8434 provides specific instructions 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, and 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.

Under the MMA, the DMEPOS CBP was to be phased in so that competition under the program would first occur in 10 Metropolitan Statistical Areas (MSAs) areas in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made other limited changes. As required by MIPPA, CMS conducted the supplier competition in nine MSAs in 2009, referring to it as the Round 1 Rebid. The Round 1 Rebid contracts and prices became effective on January 1, 2011.

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail-order competitions after 2010. The Affordable Care Act expanded the number of Round 2 MSAs from 70 to 91. Contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies went into effect on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS CBP at least once every three years. The Round 1 Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013. (The Round 1 Rebid mail-order diabetic supply contracts expired on December 31, 2012.) CMS is conducting the Round 1 Recompete in the same competitive bidding areas as the Round 1 Rebid.

You can find additional information on the DMEPOS CBP at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

More information on Round Two is also available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet. The information at this site includes information on all rounds of the CBP, including product categories; single payment amounts for the Round 1 Rebid, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.
News Flash Items
From MLN Matters Articles:

(MM8279) In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the "mailing list for referral agents" (https://public.govdelivery.com/accounts/USCMS/ subscriber/new?pop=t&topic_id=USCMS_7814) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

(MM8401 - Revised) NEW products from the Medicare Learning Network® (MLN)


(MM8404) REVISED products from the Medicare Learning Network® (MLN)

- The ICD-10 Classification Enhancements (http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10QuickRefer.pdf), Fact Sheet, ICN 903187, Hard Copy

(MM8348) MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

(MM8390) REVISED products from the Medicare Learning Network® (MLN)


(MM8268) REVISED products from the Medicare Learning Network® (MLN)


(MM8182) Re-released products from the Medicare Learning Network® (MLN)


(MM8182) Flu Season Isn’t Over – Continue to Recommend Vaccination - While each flu season is different, flu activity typically peaks in February. Yet, even in February, the flu vaccine is still the best defense against the flu. The CDC (http://www.cdc.gov/flu/freeresources/) recommends yearly flu vaccination for everyone 6 months of age and older; and although anyone can get the flu, adults 65 years and older are at greater risk for serious flu-related complications that can lead to hospitalization and death. Every office visit is an opportunity to check your patients’ vaccination status and encourage flu vaccination when appropriate. And getting vaccinated is just as important for health care personnel who can get sick with the flu and spread it to family, colleagues and patients. Be an example by getting your flu vaccine and know that you’re helping to...
reduce the spread of flu in your community. Note: influenza vaccines and their administration fees are covered Part B benefits. Influenza vaccines are NOT Part D-covered drugs. For More Information:

- **2012-2013 Seasonal Influenza Vaccines Pricing**. ([http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McPartBDrugAvgSalesPrice/VaccinesPricing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McPartBDrugAvgSalesPrice/VaccinesPricing.html))
- **HealthMap Vaccine Finder** ([http://flushot.healthmap.org/](http://flushot.healthmap.org/)) – a free, online service where users can find nearby locations offering flu vaccines as well as other vaccines for adults.
- The **CDC's** ([http://www.cdc.gov/flu/freeresources/](http://www.cdc.gov/flu/freeresources/)) website offers a variety of provider resources for the 2012-2013 flu season.

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

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

**MSI Registration – Going, going, gone!**

Have you registered for the MSI? If not, your time is running out. The MSI registration will close on Monday, September 30th. Why should I register?

- The MSI will provide the best opportunity for you to rate your satisfaction with your MAC.
- Your input will help your MAC to improve the services that they offer you
- Your opinion counts!

If you are a Medicare FFS provider or you represent a Medicare FFS provider and are interested in participating, take a moment to register your contact information by completing the application at https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA on the Internet. It will take about 1 minute to complete.

For more information visit http://www.cms.gov/Medicare/Medicare-Contracting/MSI on the CMS MSI website. Let your voice be heard!

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

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Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MLNProducts_listserv.pdf and start receiving updates immediately!

REVISED products from the Medicare Learning Network® (MLN)


ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project MLN Connects™ Video

- Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on the CMS YouTube Channel (http://www.youtube.com/watch?v=WLGofe1nPAo&feature=youtu.be), Pat Brooks and Dr. Daniel Duvall from the Hospital and Ambulatory Policy Group of the Center for Medicare discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding:
  - Hints for a smooth transition to ICD-10 in physician offices
  - ICD-10 Implementation and preparation strategies
  - Partial freeze prior to ICD-10 implementation
  - Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project at CMS
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<td>Jurisdiction C CEDI website: <a href="http://www.ngscedi.com">http://www.ngscedi.com</a> E-mail: <a href="mailto:ngs.CEDIHelpdesk@wellpoint.com">ngs.CEDIHelpdesk@wellpoint.com</a></td>
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<td>Paper Claim Submission</td>
<td>Address: CGS PO Box 20010 Nashville, TN 37202</td>
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<td>Provider Customer Service Calls</td>
<td>IVR (Interactive Voice Response): 1.866.238.9650 Mon - Fri, 6:00 a.m. - 8:00 p.m. CST; Sat, 6:00 a.m. - 4:00 p.m. CST</td>
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<td>Customer Service: 1.866.270.4909 Mon - Fri, 7:00 a.m. - 5:00 p.m. CST \ Hearing Impaired: 1.888.204.3771 Mon - Fri, 7:00 a.m. - 5:00 p.m. CST</td>
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