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Edition 31 • Spring 2015
COMPLETION OF CERTIFICATES OF MEDICAL NECESSITY
ANNUAL REMINDER

Dear Physician:

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

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are your partners in caring for your patient. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient’s treatment plan, completing the CMN accurately and in a timely manner helps ensure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) (http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) of the Act provides that:

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

Printable copies of CMNs and DIFs are available on the CMS website at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. To find the CMN/DIF you are looking for on the website, place a check next to the “Show only items containing the following word” field and enter the name of the CMN/DIF. For instance, if you are searching for the Oxygen CMN, enter the word “oxygen.” Be sure that you have selected the “Show only” option and then press the “Show Items” button.

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

Sincerely,

Robert Hoover, M.D.

Robert D. Hoover, Jr., MD, MPH, FACP
Senior Medical Director
CGS - Jurisdiction C DME MAC
On February 8, 2015, version 2.12 of myCGS was installed, implementing the transition of myCGS from the CMS IACS system to the CMS Enterprise Identity Management (EIDM) website. As a result of this upgrade, all myCGS user registration, user maintenance, and log in authentication is now performed through EIDM. If you were a registered user of myCGS prior to January 30, 2015, your previously existing IACS ID was migrated to EIDM.

If you’ve logged into myCGS since the EIDM implementation, you will have noticed that the log in process looks a little different than it did with IACS, but the steps are basically the same:

2. Select “Login to DME myCGS”
3. You will be presented with the EIDM Terms and Conditions. Press “I Accept” to agree to the terms and continue.
4. Next you will see the EIDM “Welcome to CMS Enterprise Portal” page, where you can enter your User ID and Password (see the image below). Enter your User ID and Password (the same as you used in IACS), and press the “Log In” button.
5. You will then be logged in and take to the myCGS home page.


**EIDM Account Setup**

If you are a myCGS user who was migrated from IACS (meaning you were a registered myCGS user prior to January 30, 2015), you will need to complete the setup of your EIDM accounts, including resetting their password and answering new security “challenge” questions. Completion of your EIDM account is important in order to prevent unnecessary account lockouts. Once you have completed your account setup, you will be able to easily reset your password yourself in the event of a forgotten password.

If you have not done so already, please complete the setup of your EIDM account by following these instructions:

2. Click on the Login to CMS Secure Portal button.
3. Accept the Terms and Conditions.
4. Enter your User ID and Password. This is the same User ID and password that you used in IACS (and that you use in myCGS).
5. You will then be presented with a welcome message and a prompt to complete your profile. Press Next to continue. Note that if you have already completed your account setup, you will not be presented with this screen and do not need to take further action at this time.
6. Next you will be asked to complete some personal contact information. Complete the requested information and press Next.
7. EIDM will then prompt you to change your password and to complete three security “challenge” questions. Enter your new password and then select your challenge questions, and complete the answers. Be sure to use challenge questions/answers that you will remember, as you will need to answer the challenge questions in the event of account management issues (such as if you forget your password).
8. After changing your password and answering the challenge questions, your account setup is complete. You will receive a message confirming your changes.

NOTE: Just like IACS, EIDM requires that you change your password every 60 days. You will receive email reminders when it is time to change your password.

**Changing Your Password in EIDM**

Changing your password in EIDM is easy. You can change your EIDM password at any time, but you must change it at least once every 60 days. In order to change your EIDM password, follow these steps:

2. Select the Login to CMS Secure Portal button.
3. Accept the terms and conditions, and then log in with your User ID and password.

4. Select the down arrow icon that appears next to your name at the top of page. Then, select My Profile from the drop down menu.

5. The View My Profile screen is then displayed. Select the Change Password link from the left sidebar.

6. The Change Password screen is then displayed. Enter your old password, and then create and enter a new password. Press Next to continue.

7. You will then see a confirmation of your password change. Press OK to acknowledge the change. A confirmation email will be sent to your email address.

myCGS Version 3.0—Coming Soon!

CGS is in the process of designing version 3.0 of myCGS, which will be implemented later in 2015. Version 3.0 will include a wide variety of new and exciting features that we think you’re going to love. Our goal is to make myCGS your favorite Medicare Information Tool, and we welcome your feedback on how to make it more useful.

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

To access the feedback module, log in to myCGS and click on the “Feedback” link in the upper-right corner of the screen.

The Foresee web survey will pop up on your screen automatically after you’ve logged into myCGS. Once completed, the survey will not pop up again for another 30 days.

Try myCGS Today!

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

Visit our myCGS page (http://www.cgsmedicare.com/jc/mycgs/index.html) to get started today!
Get Going with CGS Go Mobile!!!

Does this sound familiar? “No one else makes me do this – are you sure this is for Medicare?” What about that physician who refuses to change the way he completes chart notes? Or perhaps you have heard, “I sent you documents last month and now you want them again?”

If these sound familiar, then CGS Go Mobile (http://www.cmsmedicare.com/jc/onlinetools/gomobile.html) can help by providing your field marketing and delivery staff with instant access to policy-based information. Here’s how it works: If a physician tells you that no other DME supplier is asking for detailed written orders prior to delivery of certain items, you can touch the icon for “Physician Letters” and call up the letter titled “F2F and WOPD” on the CGS Go Mobile app. Read the pertinent section to the physician then offer to email it directly to them by touching the square in the upper right-hand corner above the letter! In less than a minute your marketing representative has provided policy-based information to help educate providers on the Medicare guidelines for written orders prior to delivery and the face-to-face requirements. What if the physician asks your marketing representative about Medicare’s rules for oxygen therapy? Touch the “Physician Letters” icon then touch “Home Oxygen” to see the letter that highlights Medicare’s coverage criteria for providing oxygen in the home setting. Remind the referral sources that all of the “Dear Physician” letters are authored by the DME MAC Medical Directors. As a reminder, you can touch the “Contact” icon on CGS Go Mobile and get instant access to CGS departmental addresses, phone numbers, and fax numbers.

What about the physician whose office notes is lacking key components and you have suffered denied claims during the pre-pay review process? When you schedule a visit with the physician, bring two or three related Claim Control Numbers (CCNs) with you. Touch the “MR WIZARD” icon on the CGS Go Mobile app and type in the appropriate CCN. The resulting screen details every reason why that particular claim denied. Show the physician that claims are being denied because their NPI is not on their orders or there was no proof of medical necessity for the equipment in question. Remind the physician that these claims were reviewed by clinicians at CGS and the documents were found to be missing statements necessary for payment. As such, their patients were left without the durable medical equipment ordered by the physician.


One final question…. What are you waiting for? Download CGS Go Mobile today!

Coverage & Billing

External Infusion Pumps (EIP), Supplies, and Drugs - Coverage Reminder

- Joint DME MAC Publication

A recent examination of CERT reviews for EIP claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

REASONS FOR DENIAL

- Prescriptions
  - Physician’s detailed written order is missing, incomplete, or invalid – 29%
- DME Information Form (DIF)
  - Missing DIF – 26%
- Reasonable & Necessary (R&N)
  - LCD Coverage Criteria not met – 39%
- Other
  - Continued Need Criteria not met – 3%
  - Unsigned Clinical Notes – 3%
PAYMENT RULES

Prescriptions:

All items billed to Medicare require a prescription. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. **Signature and date stamps are not allowed.** Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4 ([http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)).

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0784, as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for External Infusion Pumps (EIP) ([http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11555&ContrID=140](http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11555&ContrID=140)). The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

DME Information Form:

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. The DIF for External Infusion Pumps is CMS Form 10125 ([http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1184634.html?DLPage=2&DLSort=0&DLSortDir=ascending](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1184634.html?DLPage=2&DLSort=0&DLSortDir=ascending)). The initial claim must include an electronic copy of the DIF.

If a beneficiary begins using an infusion for one drug and subsequently the drug is changed, another drug is added, or if the code for a current drug changes, a Revised DIF must be submitted for use of the pump. The additional new or changed drug or the new HCPCS code for the existing drug must be listed along with all other drugs for which the pump is used should be included on the Revised DIF.

Reasonable and Necessary (R&N) Criteria:

This policy covers numerous drugs, and suppliers and providers are encouraged to review the specific coverage requirements for the relevant drug in question. In general, external infusion pumps and related drugs and supplies will be denied as not reasonable and necessary when the criteria described by indication (I), (II), (III), (IV) or (V) in the LCD are not met. When an infusion pump is covered, the drug necessitating the use of the pump and necessary supplies are also covered.

When a pump has been purchased by the Medicare program, other insurer, the beneficiary, or the rental cap has been reached, the drug necessitating the use of the pump and supplies is covered as long as the coverage criteria for the pump are met.

Drugs are only covered as a supply to a covered DME infusion pump. Drugs billed alone (without a covered pump being used) will be denied as statutorily noncovered (no benefit).

**Continued Medical Need:**

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary’s medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

**Documentation**

In the event of a claim review:

- Medicare requires that there is a prescription (order) for every separately billable item.
- Medicare requires that there be sufficient detailed information contained in the beneficiary’s medical record to demonstrate that the relevant policy requirements are met.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. The majority of reasons for CERT errors (55%) are completely within the purview of suppliers. Thus, suppliers are encouraged to review their claim submission practices, in order to begin to reduce the high level of CERT errors. There are
Medicare Coverage for Shoes - Correct Coding

- Joint DME MAC Publication

Medicare has limited coverage provisions for shoes used by beneficiaries. Section 1862(a)(8) of the Social Security Act (SSA) says:

［N］o payment may be made under part A or part B for any expenses incurred for items or services ... where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1861(s)(12).

SSA 1861(s)(12) describes coverage for, “extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes” when certain specified requirements are met. Reimbursement is available for shoes used by beneficiaries with diabetes when the applicable coverage requirements are met. The Therapeutic Shoes for Persons with Diabetes (TSD) Local Coverage Determination (LCD) (http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11555&ContrId=140) and related Policy Article (http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=20210&ContrId=140) address these payment rules in detail.

In addition to TSD, payment may be possible for shoes that are an integral component of a brace. CMS Internet Only Manual 100-02, Chapter 15, Section 290.B states:

Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. (Emphasis added).

These brace-related shoes are referred to as orthopedic footwear (ORF). Note that only the supplier of the brace may bill for payment for ORF in conjunction with claims for payment of the qualifying brace. Separate payment to a different supplier for shoes that are an integral component of a brace or for inserts and modifications to those shoes is not allowed. The Orthopedic Footwear LCD (http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11445&ContrId=140) and related Policy Article (http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35359&ContrId=140) address the applicable payment rules for these items.

There are situations where a beneficiary may qualify for both a diabetic shoe and a leg brace. CMS Internet Only Manual 100-02, Chapter 15, Section 140 says:

In situations in which an individual qualifies for both diabetic shoes and a leg brace, these items are covered separately. Thus, the diabetic shoes may be covered if the requirements for this section are met, while the brace may be covered if the requirements of §130 (Braces Benefit) are met. (Emphasis added).

This means that the supplier of the TSD may bill separately for TSD while a different supplier may bill for the associated brace.

There are no other categories of shoes that are eligible for Medicare reimbursement.

Different sets of HCPCS codes are used to identify the shoes, modifications, and inserts that may be eligible for payment. Suppliers must be sure to use the correct codes for each group of products.

Only HCPCS A-codes are used for TSD and related items. Only L-codes are used for ORF. Both the TSD and ORF related Policy Articles address these points.

- From TSD Policy Article
  - Codes for inserts or modifications (A5503 – A5508, A5510, A5512, A5513) may only be used for items related to diabetic shoes (A5500, A5501). They must not be used for items related to footwear coded with codes L3215 - L3253. Inserts and modifications used with L-coded footwear must be coded using L codes (L3000 - L3649).*

- From ORF Policy Article
  - Shoes, inserts, and modifications are covered in limited circumstances. They are covered in selected beneficiaries with diabetes for the prevention or treatment of diabetic foot ulcers. However, different codes (A5500-A5511) are
used for footwear provided under this benefit. See the medical policy on Therapeutic Shoes for Persons with Diabetes for details.*

- Depth-inlay or custom molded shoes for diabetics (A5500-A5501) and related inserts and modifications (A5503-A5511) are billed using these A-codes whether or not the shoe is an integral part of a brace. See the medical policy on Therapeutic Shoes for Persons with Diabetes for coverage, documentation, and additional coding guidelines.

- Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225 with a KX modifier. For these codes, one unit of service is each shoe. Oxford shoes that are not part of a leg brace must be billed with codes L3215 or L3219 without a KX modifier.

- Other shoes (e.g., high top, depth inlay or custom shoes for non-diabetics, etc.) that are an integral part of a brace are billed using code L3649 with a KX modifier. Other shoes that are not an integral part of a brace must be billed using codes L3216, L3217, L3221, L3222, L3230, L3251-L3253, or L3649 without a KX modifier.

*Note: Transferring or otherwise attaching a TSD to a brace is NOT considered a modification to the TSD. HCPCS code A5507 must not be used to bill for this service. See Orthopedic Footwear section (below) for additional information.

Orthopedic Footwear

From the Nonmedical Necessity Coverage and Payment Rules section of the ORF Policy article:

Shoes are also covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980-L2030, L2050, L2060, L2080, or L2090. Oxford shoes (L3224, L3225) are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc. (L3649), are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600-L3640) involving shoes on a covered brace are also covered. Inserts and other shoe modifications (L3000-L3170, L3300-L3450, L3465-L3520, L3550-L3595) are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Shoes and related modifications, inserts, heel/sole replacements or shoe transfers billed without a KX modifier will be denied as noncovered because coverage is statutorily excluded.

According to a national policy determination, a shoe and related modifications, inserts, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace and items related to that shoe must not be billed with a KX modifier and will be denied as noncovered because coverage is statutorily excluded.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace. Shoes which are billed separately (i.e., not as part of a brace) will be denied as noncovered. A KX modifier must not be used in this situation.

Shoes are denied as noncovered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010-L5600) which is attached to the residual limb by other mechanisms because there is no Medicare benefit for these items.

Refer to the LCDs, related Policy articles and the Supplier Manual (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8304.pdf) for additional information about coverage, coding and documentation for these items.

For questions about correct coding, contact the Pricing, Data Analysis and Coding Contractor (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 (https://www.dmepdac.com/contact/index.html).

Face-to-Face Requirements for Orders Used to Obtain Medicare Payment on ACA Items

- Joint DME MAC Publication

The Affordable Care Act (ACA) Section 6407 requires a face-to-face encounter to occur within 6 months prior to the written order prior to delivery (WOPD) for certain DME items listed within it (see “MM8304 Revised - Detailed Written Orders and Face-to-Face Encounters” http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8304.pdf). This requirement applies any time a new order has been obtained for the
purposes of Medicare payment. The only exception to the requirement for a face-to-face encounter within 6 months is when a new order is obtained due to state law, and the order is not being used as documentation to support a claim for Medicare payment. If the order is being used to meet a Medicare requirement, a new face-to-face must be conducted.

If a new order is being used as documentation to support continued medical need or to fulfill any other documentation requirement for Medicare payment, then a face-to-face encounter within 6 months prior would be required. One way to determine whether or not a new face-to-face encounter is required is to determine if the order obtained/required will be used to support Medicare payment of the claim. If the answer is “yes” then a face-to-face encounter is required within 6 months of the date prior to that order.

The face-to-face requirement became effective 7/1/13 for all ACA items and a delay in enforcement has been made by the DME MACs. Other auditing entities may enforce this requirement at this time.

MyoPro® (Myomo, Inc.) Assist Device - Correct Coding

- Joint DME MAC/PDAC Publication

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated the MyoPro® upper extremity assist device and determined that it falls within the Durable Medical Equipment (DME) benefit category. Claims for MyoPro® should be submitted using the DME miscellaneous code E1399.

Suppliers are reminded that when submitting claims for items coded E1399, the supplier must include the following information:

- Manufacturer name
- Model name or number
- Pricing information
- Explanation of medical necessity

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

This item is classified under the capped-rental payment methodology as it does not meet the requirements to be categorized as an inexpensive or routinely purchased item.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html).

Coverage and Correct Coding of Continuous Glucose Monitoring (CGM) Devices

Revised December 2014 - Joint DME MAC Publication

This article was originally posted July 2014. It is revised to allow for separate billing of supplies used with CGMs.

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

Coverage

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

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

Coding

CGM systems are provided either as complete stand-alone...
systems or with one or more components integrated into an external insulin infusion pump. For stand-alone systems and related supplies, use the following HCPCS codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9276</td>
<td>SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY</td>
</tr>
<tr>
<td>A9277</td>
<td>TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM</td>
</tr>
<tr>
<td>A9278</td>
<td>RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM</td>
</tr>
</tbody>
</table>

The following HCPCS codes are used for insulin pumps and related supplies:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0784</td>
<td>EXTERNAL AMBULATORY INFUSION PUMP, INSULIN</td>
</tr>
<tr>
<td>A4221</td>
<td>SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)</td>
</tr>
<tr>
<td>K0552</td>
<td>SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH</td>
</tr>
</tbody>
</table>

Billing

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received multiple inquiries regarding correct coding for integrated products with multiple functions, each with a separate HCPCS code.

For CGM capability that is integrated into an insulin pump, the receiver/monitor (A9278) is considered as included in the coding for the infusion pump. There is no separate or additional coding for the integrated CGM receiver/monitor. Claims for separate billing will be denied as unbundling.

For CGM capability integrated into an external insulin infusion pump, the transmitter and supplies for CGM use are separately billable. Supplies are billed using code A9276. Code A9277 should be used for the non-integrated transmitter. Claims for CGM supplies and non-integrated system components will be denied as statutorily non-covered, no benefit.


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

HyQvia® - Coverage and Correct Coding

- Joint DME MAC Publication

On September 12, 2014, HyQvia® (Baxter) was approved by the FDA for the treatment of primary immunodeficiency (PI) in adults. HyQvia® is a recombinant human hyaluronidase-facilitated subcutaneous infusion of human immunoglobulins. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated HyQvia® and determined that it is not eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).

Claims for HyQvia® will be denied as discussed in a joint DME MAC bulletin article that was posted on June 2011, titled “Drugs Used With External Infusion Pumps - Coverage and Billing Reminders” (http://www.cgsmedicare.com/jc/pubs/news/2011/0601/cope15146.html). That article described various infusion drug and pump billing scenarios and stated, in pertinent part:

1. Billing for an infusion drug alone (no pump being used). There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily non-covered.

2. Billing for a pump with an infusion drug not listed in the LCD. The External Infusion Pump is periodically updated to list specific drugs eligible for coverage. Drugs not listed in the LCD, including the associated pump and supplies, will be denied as not reasonable and necessary. HyQvia® will not be added to the LCD as a covered drug.

Claims for HyQvia® for dates of service on or after September 12, 2014 must be submitted using the DME miscellaneous code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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

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

### Integrated Respiratory Products - Correct Coding

- Joint DME MAC Publication

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have recently had multiple inquiries about the coding of products where multiple functions, each with a separate HCPCS code, are incorporated into a single product. For example, there are positive airway pressure (PAP) and respiratory assist devices (RAD) that include integrated humidification. The correct codes for the integrated product are code E0601 (Continuous positive airway pressure (CPAP) device) for the base CPAP device and code E0562 (Humidifier, heated, used with positive airway pressure device) for the integrated humidification. The same principle applies to respiratory assist devices with integrated humidification. The correct codes for the integrated RAD products are code E0470 (Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)) for the base RAD device and code E0562 for the integrated humidification.

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

### Related Information:


### Fitness Monitoring Technologies - Correct Coding

- Joint DME MAC Publication

Recently the DME MACs have received inquiries about coverage of fitness and rehabilitation tracking (FRT) technologies such as the FitBit®, WeGo®, Fuelband® and other devices such as pedometers, heart rate monitors, and GPS watches. FRTs are typically worn on the wrist and monitor the amount of exercise and movement of the wearer. FRTs are considered exercise equipment and are non-covered by Medicare. Suppliers billing FRTs must use HCPCS code A9300 (Exercise Equipment).

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or email the PDAC by completing the DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html).
DME Information Forms (DIFs)
Usage for Enteral and Parenteral Nutrition and External Infusion Pumps

- Joint DME MAC Publication

The DME MACs use DME Information Form (DIF) when processing claims to assure the most current information is on file and to allow the claims to pay correctly. Claims for enteral and parenteral nutrition and external infusion pumps require a DIF to be submitted with the initial claim as well as when changes in the items or quantities provided are made. DIFs are completed entirely by the supplier and do not need to be signed by the treating physician. DIFs are required to be signed and dated by the supplier.

The following table indicates the DIFs for external infusion pumps and enteral/parenteral nutrition.

<table>
<thead>
<tr>
<th>DME MAC FORM</th>
<th>CMS FORM</th>
<th>ITEMS ADDRESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.03</td>
<td>10125</td>
<td>External Infusion Pumps</td>
</tr>
<tr>
<td>10.03</td>
<td>10126</td>
<td>Enteral and Parenteral Nutrition</td>
</tr>
</tbody>
</table>

The Initial DIF: A new Initial DIF is required when:

1. An enteral formula billed with a different code, which has not been previously certified, is ordered; or,

2. For either enteral formulas or administration via pump (B9000 or B9002), there has been a break in billing of more than 60 days (plus the remaining days in the rental month) and there has been a change in the underlying medical condition that justifies coverage for the item(s).

3. A beneficiary receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump* (B9000 or B9002).

*Change in method of administration from gravity or syringe to a pump (B9000 or B9002) requires a new initial DIF for the pump and a revised DIF for the enteral nutrient (See chart below).

The Revised DIF: Required when there has been a change in any of the information recorded on the DIF. The table below lists changes that require a Revised DIF to be submitted:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in the drug HCPCS code</td>
<td>External Infusion</td>
</tr>
<tr>
<td>Change in the route of administration</td>
<td>External Infusion</td>
</tr>
<tr>
<td>Change in method of administration</td>
<td>External Infusion</td>
</tr>
<tr>
<td>Change in HCPCS code for the current nutrient provided</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Change (increase or decrease) in the calories prescribed</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Change in the method of administration from gravity to syringe or syringe to gravity (See above for gravity or syringe to pump)</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Change in the number of days per week of administration</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Change in route of administration from tube feedings to oral feedings (if billing for denial)</td>
<td>Nutrition</td>
</tr>
</tbody>
</table>

The Recertification DIF: Must be submitted when the length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s).


For additional information, refer to the Supplier Manual (http://www.cgsmedicare.com/jc/pubs/supman/index.html), the applicable Local Coverage Determination, and related Policy Article.
Cast Covers - Correct Coding  
- Joint DME MAC Publication

Recently the DME MACs have received inquiries about coverage of covers for casts. These are typically constructed of latex or rubber and are designed to fit over a cast to allow bathing, showering or swimming without water infiltration. Medicare considers cast covers a convenience item; therefore, these items are non-covered. The proper HCPCS code for cast covers is:

A9270 – Non-covered item or service

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html).

New Oral Antiemetic Drug 
Akynzeo® - Coverage and Coding  
- Joint DME MAC Publication

Effective Date: November 10, 2014

The U.S. Food and Drug Administration approved Akynzeo® on October 10, 2014. Akynzeo® is a combination medication used to treat nausea and vomiting in patients undergoing cancer chemotherapy.

Akynzeo® is a fixed combination capsule comprised of two drugs, oral palonosetron (a 5HT3 antagonist) and netupitant (a NK-1 antagonist). The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Akynzeo® and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drug (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after October 10, 2014.

The use of the oral anti-emetic 3-drug combination of an FDA-approved oral NK-1 antagonist and an oral 5HT3 antagonist, in combination with dexamethasone, is covered if, in addition to meeting the statutory coverage criteria specified in the related Policy Article, they are administered to beneficiaries who are receiving one or more of the anti-cancer chemotherapeutic agents listed in the LCD regarding oral anti-emetic coverage.

Claims for Akynzeo® must be billed using NOC code Q0181, and must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage and there must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (Q0181) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral antiemetics, a KX modifier must be added to each code. Further instructions in that policy include but are not limited to the following items.

In addition to the diagnosis code corresponding to the beneficiary’s cancer diagnosis, claims for these drugs must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (V58.11).

Any claims for code Q0181 must be accompanied by the name of the drug, the manufacturer, the dosage strength dispensed, the number of capsules and frequency of administration during the covered time period (24-48 hours) as specified on the order. (Note the time span of coverage remains as stated in the LCD). This information should be entered in the narrative field of an electronic claim.

If Akynzeo® (Q0181) and dexamethasone (J8540) are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of this policy, the GA or GZ modifier must be added to the claim lines for Q0181 and J8540. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

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

Requirements

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

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

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

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

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

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

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

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

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

Billing Frequencies

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

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

Miscellaneous

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

For additional information, refer to CMS’ Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c05.pdf), and the applicable Local Coverage Determinations (http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=140&name=CGS%20Administrators,%20LLC%20(18003,%20DME%20MAC)&DocType=All&ContrVe=r=2&ContrctrSelected=140*2&LCntrctr=140*2&bc=AgACAAIAAAAAA%3d%3d&%20-%20ResultsAnchor#ResultsAnchor) and the Supplier Manual (http://www.cgs medicare.com/jc/pubs/supman/index.html).

Modifier Requirements Due To Lack of a Physician’s Order (Modifier EY)

We have recently received inquiries regarding the proper submission of modifiers EY, GY and GA when a denial is anticipated due to the lack of a prescription. To reduce errors related to this process, it is important to remember that all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items require a prescription (physician’s order). Some DMEPOS items require a detailed written order prior to dispensing (WOPD), while others require a detailed written order (DWO) prior to billing. The specific requirements for an order are specified in the Medical Policy (Local Coverage Determination and/ or Policy Article) for the specific item.

Please remember that if you submit a claim to Medicare and specified requirements for an order are not met, you must append modifier EY (“No physician or other licensed health care provider order for this item or service”) to the claim line. This informs the
Durable Medical Equipment, Medicare Administrative Contractor (DMEMAC) that you do not have a physician’s order for the item. Additionally, items submitted with the EY modifier must be on a separate claim from those items not requiring an EY modifier.

When lack of an order is expected to result in a medical necessity denial (ANSI 50 — “These are non-covered services because this is not deemed a 'medical necessity' by the payer”), you must execute an Advance Beneficiary Notice of Noncoverage (ABN) if you intend to protect your company from financial liability. If you have properly executed an ABN, you must append modifier GA (“Waiver of liability statement issued as required by payer policy, individual case”) to the claim line in addition to modifier EY.

However, when the lack of a physician’s order is expected to result in a statutory denial, an ABN is not required. If you correctly submit the claim with modifier EY appended to the claim line, the claim will process and deny with ANSI 96 (“Non-covered charge(s)”). Neither modifier GY (“Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit”) nor modifier GA is required when an item is expected to deny on the basis of a statutory denial (ANSI 96).

As a reminder, all items specified in Change Request 8304 which are subject to the Affordable Care Act 6407 require a WOPD. This is a statutory requirement. You must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. If you deliver the item prior to your receipt of a written order, it will be denied as statutorily noncovered. Therefore, when you do not have an order for these items, you must submit the claim with modifier EY. Again, neither modifier GY nor GA would be required.

We encourage you to refer to the LCD (http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?CnttrId=140&name=CGS%20Administrators,%20LLC%20(18003,%20DME%20MAC)&DocType=Active&Con trVer=2&CntrctrSelected=140*2&LCntrctr=140*2&bc=AgACAAIAAAAAA%3d%3d&#ResultsAnchor) and related Policy Article (http://www.cms.gov/medicare-coverage-database/indexes/article-list.aspx?CnttrId=140&ContrVer=2&CntrctrSelected=140*2&name=CGS+Administrators,+LLC+(18003,+DME+MAC)&LCntrctr=140*2 &bc=AgABAAAAAAAAAAAAAA#ResultsAnchor) for specific order and other documentation requirements for the items you provide.

Related Information:

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Non-Invasive Interfaces Used in Conjunction with HCPCS Code E0472 - Correct billing

- Joint DME MAC Publication

Recently during claims review it was noted that suppliers are billing HCPCS code E0472 (RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)) with non-invasive interfaces. This is not correct billing. As noted in the code descriptor, code E0472 is reserved for devices used with an invasive interface. Claims for E0472 must not be billed with any of the following non-invasive interfaces or accessories:

- A7027 - COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH
- A7028 - ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH
- A7029 - NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR
- A7030 - FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
- A7031 - FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH
- A7032 - CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH
- A7033 - PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR
- A7034 - NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP
- A7035 - HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE
- A7036 - CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE
- A7044 - ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
Claims for devices used with a non-invasive interface are billed with HCPCS codes E0470 or E0471, depending on whether or not the device has a backup rate feature.

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

Reference Information:

Osteogenesis Stimulators - Coverage Reminder

- Joint DME MAC Publication

A recent examination of CERT reviews for osteogenesis stimulator claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

REASONS FOR DENIAL
- Prescriptions
  - Physician’s detailed written order is missing, incomplete, or invalid – 25%
- Reasonable & Necessary (R&N)
  - National Coverage Determination (NCD) for osteogenesis stimulators (150.2) coverage criteria for radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with E0747 not met – 53%
- Other
  - Face-to-face requirement not met – 6%
  - Missing CMN – 3%
  - Unsigned Clinical Notes or use of Signature Stamps – 9%

PAYMENT RULES

Prescriptions:
All items billed to Medicare require a prescription. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in IOM 100-08, Chapter 3, 3.2.4 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the Local Coverage Determination (LCD) for Osteogenesis Stimulators. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

Face-to-Face Documentation:
ACA 6407 requires face-to-face documentation that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for Osteogenesis Stimulators.

Reasonable and Necessary (R&N) Criteria:
The NCD and LCD for Osteogenesis Stimulators both mandate that coverage for a non-spinal electrical osteogenesis stimulator (E0747) is covered for nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator (criteria 1). Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
In the event of a claim review:

- Medicare requires a WOPD.
- Medicare requires face-to-face documentation.
- Medicare requires that there be sufficient detailed information contained in the beneficiary’s medical record to demonstrate that the relevant policy requirements were met.

This article presents a summary of the policy requirements related to the errors identified in a CERT review. There are additional requirements necessary for coverage that are not discussed in this article. Please refer to the Osteogenesis Stimulator LCD (http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5012&ContrID=140) and related Policy article (http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=25956&ContrID=140) for complete information.

Further education regarding this policy is available on DME MAC Jurisdiction C contractor website (http://www.cgsmedicare.com/jc/index.html).

Peristeen® Transanal Irrigation System - Correct Coding and Coverage

- Joint DME MAC Publication

The Peristeen® transanal irrigation system is a device used to empty the lower bowel and to prevent chronic constipation and fecal incontinence or simply as a method of bowel management. The system consists of an enema bag, a rectal catheter with an inflatable balloon and a pump. Effective for claims with dates of service on or after January 1, 2015 the correct code to bill is:

A4459 – MANUAL PUMP ENEMA SYSTEM, INCLUDES BALLOON, CATHETER AND ALL ACCESSORIES, REUSABLE, ANY TYPE

There is no Medicare benefit for this device; therefore, claims for code A4459 will be denied as non-covered (no Medicare benefit).

Code A4459 is an all-inclusive code at initial issue. Separate billing of any of the individual components is not allowed. The code is established as a single code to include all parts including the disposable supplies at initial issue. For refills of disposable supplies such as rectal catheters, HCPCS code A9270 (Noncovered item or service) should be used.

For questions about correct coding, contact the Pricing Data Analysis and Contractor (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 (https://www.dmepdac.com/contact/index.html).

Proof of Delivery Reminder

- Joint DME MAC Article

Recently during claims review it was noted that suppliers have a misunderstanding about the purpose of proof of delivery (POD). All items of durable medical equipment, prosthetics, orthotics and supplies require POD. Proof of delivery serves multiple purposes, the most obvious being confirmation that the beneficiary received the item for which Medicare was billed. In addition to confirming receipt of an item, POD also serves other functions in Medical Review, specifically the ability of contractor’s review staff to determine correct coding. As noted in the Documentation Section of the DME MAC local coverage determinations (LCDs) (http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Contracr=140&ContrVer=2&CntrcrSelected=140%26name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrcr=140%26DocType=Active&bc=AgACAAAAAA%3d%3d#ResultsAnchor):

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

To enable review staff to make a correct coding determination, there must be sufficient details about the item delivered to ascertain whether or not the item(s) on the detailed written order are the same item(s) included on the claim and coded with the correct HCPCS code. To accomplish this task, the POD must contain specific information about the products to make this determination. As noted in the DME MAC LCD Documentation Section for each of the three methods of delivery, one of the requirements for proper POD documentation is:
Reviewers often see a reiteration of the HCPCS code narrative on the POD form as the detailed description of the item, particularly for orthotics and prosthetics. This is NOT adequate for POD purposes. Simply restating the HCPCS code narrative description does not allow review staff to determine what specific item(s) is being billed and if it is coded correctly. The preferred method is use of a brand name and model number, brand name and serial number or manufacturer name and part number to identify the product. If this type of information is not available for the product, suppliers may use a detailed narrative description of the item; however, it must contain sufficient descriptive information to allow a proper coding determination. This “narrative description” of the item is not the HCPCS code narrative.

Proof of delivery documents that fail to properly identify DMEPOS products and allow reviewers to make a correct coding determination will be denied for insufficient delivery information.

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

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

Claims for Blincyto™ for dates of service on or after December 03, 2014, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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


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

Blincyto™ - Coverage and Correct Coding

- Joint DME MAC Publication

On December 03, 2014, the FDA gave accelerated approval for Blinatumomab (Blincyto™) for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Blincyto™ is a bispecific CD19-directed CD3 T-cell engager that activates endogenous T cells when bound to the CD19-expressing target cell (B cells). Activation of the immune system results in release of inflammatory cytokines. The FDA-approved schedule is for 6-week cycles, for a total 5 cycles.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Blincyto™ and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).
Duopa® (Levodopa-Carbidopa Enteral Suspension) - Coverage and Correct Coding

- Joint DME MAC Publication

On January 09, 2015, Duopa® (AbbVie) was approved by the FDA. Duopa® is an enteral-suspension combination of levodopa and carbidopa, and is indicated for the treatment of Parkinson’s disease (PD). Duopa® is administered as a continuous 16-hour infusion into the jejunum through a percutaneous endoscopic gastrostomy-jejunal tube (PEG-J), using a CADD®-Legacy 1400 portable infusion pump.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Duopa® and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD). Refer to the External Infusion Pump LCD and Policy Article for specific coverage requirements.

Claims for Duopa® for dates of service on or after January 09, 2015 must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:
- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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

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


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

Responding to ADR Letters: Common Errors and Solutions

CGS continues to see issues with supplier responses to the ADR letters. This article highlights some common errors and reminds you of the ADR tools and resources that are available at CGSMedicare.com that can help you avoid delays in processing your claims.

When a claim is selected for review or, when additional documentation is needed to complete the processing of a claim, Medicare contractors, including CGS, will send you an additional development request letter (ADR). We have a sample letter available on our website (http://www.cgsmedicare.com/jc/claims/adr.html). The ADR letter is very detailed and it clearly lists specific documentation and/or medical records for each claim or claim line identified that must be submitted for review before the claim can be processed. The ADR letter details the specific claim under review including the dates of service, the submitted amount, and the HCPCS code and modifier(s) billed. The documentation we are requesting is always specific to the claim(s) listed in the letter. The required documentation is then listed beneath the claim information. Submitting the correct documentation for each requested item helps verify that items submitted on your claim meet policy requirements, are coded correctly, and/or are paid based on Medicare guidelines.

Two of the most common errors we see at CGS involve either too much documentation (or documentation that was not requested) or, not enough documentation. Put simply, when responding to the request, only send the documents that are requested by the ADR letter. Additional, unrelated documentation slows the review process and delays processing.

If you are unsure what specific documents are needed or why they have been requested, you can use our online ADR tool (http://www.cgsmedicare.com/medicare_dynamic/jc/adr.asp).
Simply enter the ADR letter number and the tool will provide specific information regarding the type(s) of documentation required to complete the processing of your claim. The ADR tool will also let you know who requested the documentation and it provides links to additional education and information available for the specific documentation requested.

Here’s an example of how our online ADR tools and information can benefit you. If you are submitting oxygen claims and the ADR Online Tool and letter indicates that the Appeals department needs progress notes within thirty days prior to the initial date on the CMN, then the progress notes are the only documents Appeals needs. Our online tool will link you to regulatory requirements for progress notes if you need additional information. Or, if you are submitting claims for test strips and lancets and the ADR Online Tool and letter indicates that the Appeals department needs proof of delivery or a refill request, then that is all you need to send. Again, our tool will link you to instructions specific to test strips and lancets. It is very important that your documentation clearly shows the requested information.

We encourage you to use our online ADR resources as you prepare your documentation. We have provided step-by-step information on the correct way to prepare your documentation in response to the ADR letter request and we offer helpful information to avoid other common errors.


Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category


MLN Matters® Number: MM8566 Revised
Related Change Request (CR) #: CR 8566
Related CR Release Date: December 5, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R1445OTN
Implementation Date: April 7, 2014

Note: This article was revised on December 9, 2014, to reflect the revised CR8566 issued on December 5. The CR was revised to add a caret (^) to code E2378 in the table in Attachment A of the CR denoting this is an item which can be billable with complex rehabilitative wheelchair codes K0835-K0864. In the article, the CR release date, transmittal number, and the Web address for accessing CR8566 are revised also. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries. In addition, this MLN Matters® Article is intended to clarify the interaction between these Part B coding changes and the bundled Part A payment that SNFs receive for a resident’s Medicare-covered stay.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8566 as a one-time notification that provides instructions regarding the reclassification of certain DME from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category for the Healthcare Common Procedure Coding System (HCPCS) codes listed in ‘Attachment A’ of CR8566. Be sure your billing personnel are aware of these changes.
Background

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the Social Security Act (the Act). The Medicare definition of routinely purchased durable medical equipment (DME) set forth at 42 CFR 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, showed inconsistencies in applying the definition.

As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. CMS-1526-F is available at http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf on the Internet.

Also in the rule, CMS established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) are payable under the lump sum purchase method. The complex rehabilitative power wheelchair base codes and options/accessories are payable under the lump sum purchase method set forth at 42 CFR 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Act.

In order to align the payment category with the required regulatory definition, certain HCPCS codes listed in Attachment A will reclassify from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category. Instructions for billing capped rental items can be found at "Medicare Claims Processing Manual" (Pub. 100-04), Chapter 20, Section 130.9 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf along with other sources listed on the CMS and contractor websites.

Be aware the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP) as shown in Attachment A of CR8566. A forthcoming CR will address the codes that are reclassifying to the capped rental payment category effective July 1, 2016, and January 1, 2017.

As shown in the table below, HCPCS codes for items included under the Round 2 and/or Round 1 Recompete DMEPOS CBPs will transition to the capped rental payment category in stages.

### Payment Category Transition Effective Dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2014</td>
<td>HCPCS codes not included in a CBP are reclassified from IN DME to CR DME in all areas</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>HCPCS codes included in a CBP are reclassified from IN DME to CR DME in all areas except the 9 Round 1 Recompete CBAs, where items furnished to beneficiaries residing in these areas will remain in, IN DME through December 31, 2016</td>
</tr>
<tr>
<td>January 1, 2017</td>
<td>HCPCS codes included in a CBP are reclassified from IN DME to CR DME in the 9 Round 1 Recompete CBAs</td>
</tr>
</tbody>
</table>

When the HCPCS codes listed below are furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete CBP, the payment category transition from inexpensive and routinely purchased to capped rental DME is effective January 1, 2017.

### HCPCS for Items Reclassified to Capped Rental DME Category Effective July 1, 2016*

- Support Surfaces: E0197
- Walkers: E0140 & E0149
- Wheelchairs Options/Accessories: E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070
- Wheelchair Seating: E0955

* Items furnished in accordance with Round 1 Recompete contracts reclassify effective January 1, 2017

### Complex Rehabilitative Power Wheelchair Accessories

Effective April 1, 2014, for wheelchair accessory codes classified under the capped rental DME payment category and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. These accessory items would be considered as part of the complex rehabilitative power wheelchair (codes K0835 – K0864) and associated lump sum purchase option set forth at 42 CFR 414.229(a)(5).

If the beneficiary declines the purchase option, the supplier must furnish the items on a rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

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Note: Items Needed During a Covered Part A Stay in a SNF

For an SNF resident whose stay is covered by Part A of Medicare, the extended care benefit provides comprehensive coverage for the overall package of institutional care that the SNF furnishes. This coverage includes any medically necessary durable medical equipment (DME) under the heading of “...drugs, biologicals, supplies, appliances, and equipment...” (section 1861(h)(5) of the Social Security Act (the Act)).

Accordingly, in cases where such a resident has a medical need for DME during the course of the Part A stay, the SNF is obligated to furnish it, since the SNF’s global per diem payment for the covered stay itself already includes any medically necessary DME. For an SNF resident whose stay is covered by Part A of Medicare, the extended care benefit provides comprehensive coverage for the overall package of institutional care that the SNF furnishes. This coverage includes any medically necessary durable medical equipment (DME) under the heading of “...drugs, biologicals, supplies, appliances, and equipment...” (section 1861(h)(5) of the Social Security Act (the Act)).

Prior to April 1, 2014, and the change in Medicare Part B payment rules addressed in this article, Medicare beneficiaries may have brought this equipment purchased under Part B with them for use during a covered Part A stay in a SNF. This may still be the case for beneficiaries who take over ownership of the equipment after 13 months of continuous Part B rental payments.

However, in those cases where the beneficiary enters a SNF under a covered Part A stay and is in the middle of the 13-month capped rental period under Part B for the item, it is the responsibility of the SNF to ensure that the beneficiary has access to this equipment if it is medically necessary while the beneficiary is in the SNF during the Part A stay.

Additional Information

The official instruction, CR 8566 along with Attachment A, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1445OTN.pdf on the CMS website. Attachment A is also repeated at the end of this article.

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.

### Attachment A

Inexpensive & Routinely Purchased (IN) Items Reclassified to Capped Rental (CR)

<table>
<thead>
<tr>
<th>Group Category</th>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Effective 4/1/14</th>
<th>Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</th>
<th>Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automatic External Defibrillator</td>
<td>K0607</td>
<td>Repl battery for AED</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Canes/ Crutches</td>
<td>E0117</td>
<td>Underarm spring assist crutch</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Glucose Monitor</td>
<td>E0620</td>
<td>Capillary blood skin piercing device laser</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>High Frequency Chest Wall Oscillation Device (HFCWO)</td>
<td>A7025</td>
<td>Replace chest compress vest</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospital Beds/ Accessories</td>
<td>E0300</td>
<td>Enclosed ped crib hosp grade</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Misc. DMEPOS</td>
<td>A4639</td>
<td>Infrared ht sys replacement pad</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>E0762</td>
<td>Trans elec jt stim dev sys</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>E1700</td>
<td>Jaw motion rehab system</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nebulizers &amp; Related Drugs</td>
<td>K0730</td>
<td>Ctrl dose inh drug deliv system</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other Neuromuscular Stimulators</td>
<td>E0740</td>
<td>Incontinence treatment system</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>E0764</td>
<td>Functional neuromuscular stimulation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pneumatic Compression Device</td>
<td>E0656</td>
<td>Segmental pneumatic trunk</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>E0657</td>
<td>Segmental pneumatic chest</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Power Operated Vehicles</td>
<td>E0984</td>
<td>Add pwr tiller</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Group Category</td>
<td>HCPCS</td>
<td>Descriptor</td>
<td>Effective 4/1/14</td>
<td>Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</td>
<td>Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</td>
</tr>
<tr>
<td>----------------</td>
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<td>-----------------</td>
<td>-----------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Speech Generating Devices</td>
<td>E2500</td>
<td>SGD digitized pre-rec &lt;=8min</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2502</td>
<td>SGD prerec msg &gt;8min &lt;=20min</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2504</td>
<td>SGD prerec msg &gt;20min &lt;=40min</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2506</td>
<td>SGD prerec msg &gt; 40 min</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2506</td>
<td>SGD spelling phys contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2510</td>
<td>SGD w multi methods msg/ access</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Surfaces</td>
<td>E0197 *</td>
<td>Air pressure pad for mattress</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0198</td>
<td>Water pressure pad for mattress</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traction Equipment</td>
<td>E0849</td>
<td>Cervical pneum traction equip</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0855</td>
<td>Cervical traction equipment</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0856</td>
<td>Cervical collar w air bladder</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walkers</td>
<td>E0140 *</td>
<td>Walker w trunk support</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0144</td>
<td>Enclosed walker w rear seat</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0149 *</td>
<td>Heavy duty wheeled walker</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchairs Manual</td>
<td>E1161</td>
<td>Manual adult wc w tilt/nspc</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1232</td>
<td>Folding ped wc tilt-in-space</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1233</td>
<td>Rig ped wc tilt/nspc w/o seat</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1234</td>
<td>Fold ped wc tilt/nspc w/o seat</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1235</td>
<td>Rigid ped wc adjustable</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1236</td>
<td>Folding ped wc adjustable</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1237</td>
<td>Rgd ped wc adjstabl w/o seat</td>
<td>■</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1238</td>
<td>Fold ped wc adjstabl w/o seat</td>
<td>■</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Wheelchair Options / Accessories | E0985 * | W/c seat lift mechanism | ■ | |
| | E0986 | Man w/c push-rim pow assist | ■ | |
| | E1002 ^ | Pwr seat tilt | ■ | |
| | E1003 ^ | Pwr seat recline | ■ | |
| | E1004 ^ | Pwr seat recline mech | ■ | |
| | E1005 ^ | Pwr seat recline pwr | ■ | |
| | E1006 ^ | Pwr seat combo w/o shear | ■ | |
| | E1007^ | Pwr seat combo w/shear | ■ | |
| | E1008 ^ | Pwr seat combo pwr shear | ■ | |
| | E1010 ^ | Add pwr leg elevation | ■ | |
| | E1014 | Reclining back add ped w/c | ■ | |
| | E1020 * | Residual limb support system | ■ | |
| | E1028 * | W/c manual swingaway | ■ | |
| | E1029 | W/c vent tray fixed | ■ | |
| | E1030 ^ | W/c vent tray gimbaled | ■ | |
| | E2227 | Gear reduction drive wheel | ■ | |
| | E2228 * | Mwc acc, wheel-chair brake | ■ | |
| | E2310 ^ | Electro connect btw control | ■ | |
| | E2311 ^ | Electro connect btw 2 sys | ■ | |
| | E2312 ^ | Mini-prop remote joystick | ■ | |
| | E2313 ^ | PWC harness, expand control | ■ | |
| | E2321 ^ | Hand interface joystick | ■ | |
| | E2322 ^ | Mult mech switches | ■ | |
| | E2325 ^ | Sip and puff interface | ■ | |
| | E2326 ^ | Breath tube kit | ■ | |
| | E2327 ^ | Head control interface mech | ■ | |
| | E2328 ^ | Head/extremity control interface | ■ | |
| | E2329 ^ | Head control interface nonproportional | ■ | |
New Timeframe for Response to Additional Documentation Requests


MLN Matters® Number: MM8583 Revised
Related Change Request (CR) #: CR 8583
Related CR Release Date: February 4, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R567PI
Implementation Date: April 6, 2015

Note: This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare’s Common Working File (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:
• The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

• According to the “Medicare Program Integrity Manual,” Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional Information


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

New Informational Unsolicited Response (IUR) Process for Durable Medical Equipment (DME) Items Furnished during a Part A Inpatient Stay


MLN Matters® Number: MM8844
Related Change Request (CR) #: CR 8844
Related CR Release Date: November 6, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R1435OTN
Implementation Date: April 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for hospitals and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for DMEPOS items provided to Medicare beneficiaries while an inpatient in an inpatient facility, or other facility.

Provider Action Needed

Change Request (CR) 8844 is a modification of CR8172 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) longstanding edits in place to deny claims for DME items furnished during an inpatient stay. CR8172 only addressed Prosthetics and Orthotics and did not include DME. In addition, CR8172 provided instructions for the date of service through discharge date, but did not include day of discharge.

CR8844 provides a modification to include DME and discharge date to the Informational Unsolicited Response (IUR) edit process for DME during a Part A Inpatient Stay. Effective April 1, 2015, Medicare’s Common Working File (CWF) will update the existing 7201 IUR edit to trigger recoupment for DME items furnished while the beneficiary was in a hospital inpatient stay. Make sure your billing staffs are aware of these changes.

Background

Section 1861(n) of the Social Security Act limits Part B coverage under the DME benefit to those items that are furnished for...
use in a patient's home. Inpatient facilities, and other facilities, may not be considered the patient's home. Therefore, payment for DME items may not be made while the beneficiary is in an inpatient facility, or other facility. This applies to the following Healthcare Common Procedure Coding System (HCPCS) categories:

- 01 - Capped Rental DME;
- 02 - Frequently maintained DME;
- 04 - Inexpensive and routinely purchased DME;
- 05 - Electric Wheelchairs;
- 06 - Oxygen equipment; and
- 07 - Oxygen Supplies.

Note: This does not apply when the DME claim has a patient status code of 03 or 83 AND the Skilled Nursing Facility (SNF) claim is not on file. Also, the edit will not apply if the "From" date of the DME claim is the same as an inpatient discharge date and the patient status code on the inpatient claim is 01 (Discharged to home or self-care), 06 (Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care), 50 (Discharged/transferred to Hospice - home), 81 (Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission), or 86 (Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission).

CMS has edits in place to deny claims for DME items furnished during an inpatient stay. Currently, however, no process is in place to recoup funds for DME items when the bill for the inpatient stay is received after the DME claim.

Effective April 1, 2015, CMS is creating a new IUR process within the CWF to identify DME claims that overlapped a Part A inpatient stay. An IUR identifies a claim that needs to be adjusted by the Medicare Administrative Contractor (MAC). The MAC will receive information from CWF as a result of the IUR, and initiate, when appropriate, the recoupment process for DME items furnished during an inpatient stay.

When your MAC denies a claim for DME when the beneficiary is in an inpatient stay, the denial will include the following remittance codes:

- Reason Code 96 - Non covered charge(s)
- Remark Code M18 - Certain Services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home
- Group Code PR – Patient Responsibility

Additional Information


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

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


**MLN Matters® Number:** MM8994  
**Related Change Request (CR) #:** CR 8994  
**Related CR Release Date:** December 5, 2014  
**Effective Date:** April 1, 2015  
**Related CR Transmittal #:** R3143CP  
**Implementation Date:** April 6, 2015

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 8994 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staff are aware of these changes.

**Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January, June, and October) and makes decisions about additions of new codes, as well as modifications.

These pages have previously been referenced at http://www.wpc-edi.com/codes on the Internet. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation and are to be reflected in ASC X12 277 transactions issued on and after the date of implementation of CR 8994.

Additional Information


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

ICD-10

International Classification of Diseases, Tenth Revision (ICD-10)
Limited End to End Testing with Submitters for 2015


MLN Matters® Number: MM8867
Related Change Request (CR) #: CR 8867
Related CR Release Date: January 20, 2015
Related CR Transmittal #: R1451OTN
Effective Dates: September 12, 2014 - for MACs and CEDI (non-systems change requirements) (Note: This is the due date of the first MAC and CEDI requirement); January 26, 2015 - for FISS and CEDI coding for January Testing Week; April 27, 2015 - for FISS and CEDI coding for April Testing Week; July 20, 2015 - for FISS and CEDI coding for July Testing Week.

Implementation Dates: January 5, 2015 - for FISS and CEDI coding for January Testing Week; February 16, 2015 - for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable.; April 6, 2015 - for FISS and CEDI coding for April Testing Week; May 18, 2015 - for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015 - for FISS and CEDI coding for July Testing Week; August 10, 2015 - for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

Provider Types Affected

This MLN Matters® Article is intended for providers and clearinghouses wishing to submit test claims with ICD-10 codes to Medicare Administrative Contractors (MACs).

What You Need to Know

Change Request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to ICD-10.
The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

**Background**

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR8867 will allow a small subset of submitters to test with MACs and the Common Electronic Data Interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR8867 requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
  - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
  - MACs and CEDIs will post the form to their website by March 13, 2015, for the July 2015 testing.
  - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
  - By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the Health Insurance Claim Numbers (HICNs), Provider Transaction Access Number (PTANs), and National Provider Identifiers (NPIs) the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.
- Testers selected in the January 2015 Testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.
- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language
● MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.

● MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.

● CEDI will instruct suppliers to submit claims with ICD-10 code with Dates of Service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with Dates of Service before October 1, 2015.

● MACs will instruct testers to submit test claims with ICD-10 code with Dates of Service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with Dates of Service before October 1, 2015.

● MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.

● MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.

● MACs and CEDIs will post an announcement about the testing to their websites. The announcement will be provided by CMS.

Additional Information


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

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


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

Note: This article was revised on December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods.

Provider Types Affected

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

Provider Action Needed

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

Background

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

**CMS Internal Testing of Its Claims Processing Systems**

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

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

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

**Provider-Initiated Beta Testing Tools**

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

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

**Acknowledgement Testing**

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

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

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

**End-to-End Testing**

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

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

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

Claims Submission Alternatives

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

Additional Information

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

FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing


MLN Matters® Number: SE1435 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on December 24, 2014, to add FAQs 6-8 on page 3 and the former FAQ 6 is now FAQ 9. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.
Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to Know Prior to Testing

1. How is ICD-10 end-to-end testing different from acknowledgement testing?

The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. What constitutes a testing slot for this testing?

A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. What data must I provide to the MAC before testing?

For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. What should I consider when choosing HICNs for testing?

The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?

No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?

A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. Do you have information on who has been selected for the January 2015 end-to-end testing?

We will release this information as part of the public release of our January test results.

8. When do you expect to publically release results of the first round of end-to-end testing?

We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

9. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?

Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to Know During Testing

1. Is it safe to submit test claims with Protected Health Information (PHI)?
The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. **What Dates of Service can be used on test claims?**

   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

   For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. **Can both ICD-9 and ICD-10 codes be submitted on the same claim?**

   ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to MLN Matters® Article SE1325, “Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date” located at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf) on the Centers for Medicare & Medicaid Services website.

4. **Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP’d claims be re-submitted for testing?**

   Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP’d will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

   Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. **If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**

   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

   If the beneficiary’s CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

   If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**

   You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required.
You do not need to submit the supporting data sheets.

Additional Information

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


MLN Matters® Number: SE1501
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies who participate in Medicare ICD-10 acknowledgement testing and who are selected to participate in end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When “you” is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

<table>
<thead>
<tr>
<th>Question</th>
<th>Acknowledgement Testing</th>
<th>End-to-End Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I need to register for testing?</td>
<td>No, you do not need to register for acknowledgement testing.</td>
<td>Yes, end-to-end testing volunteers must register on their Medicare Administrative Contractor (MAC) website during specific time periods.</td>
</tr>
<tr>
<td>Who can participate in testing?</td>
<td>Acknowledgement testing is open to all Medicare Fee-For-Service (FFS) electronic submitters.</td>
<td>End-to-end testing is open to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare FFS direct submitters;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Direct Data Entry (DDE) submitters who receive an Electronic Remittance Advice (ERA);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clearinghouses; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Billing agencies.</td>
</tr>
<tr>
<td>How many testers will be selected?</td>
<td>All Medicare FFS electronic submitters can acknowledgement test.</td>
<td>50 end-to-end testers will be selected per MAC jurisdiction for each testing round. You must be selected by the MAC for this testing.</td>
</tr>
<tr>
<td>What will the testing show?</td>
<td>The goal of acknowledgement testing is to demonstrate that:</td>
<td>The goal of end-to-end testing is to demonstrate that:</td>
</tr>
<tr>
<td></td>
<td>• Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes;</td>
<td>• Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;</td>
</tr>
<tr>
<td></td>
<td>• Providers submitted claims with valid National Provider Identifiers (NPIs);</td>
<td>• Software changes the Centers for Medicare &amp; Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and</td>
</tr>
<tr>
<td></td>
<td>• The claims are accepted by the Medicare FFS claims systems; and</td>
<td>• Accurate Remittance Advises are produced.</td>
</tr>
<tr>
<td></td>
<td>• Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.</td>
<td></td>
</tr>
<tr>
<td>Will the testing test National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?</td>
<td>No, acknowledgement testing will not test NCDs and LCDs.</td>
<td>Yes, end-to-end test claims will be subject to all NCDs and LCDs.</td>
</tr>
</tbody>
</table>
Will the testing confirm payment and return an ERA to the tester?
No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.

Yes, end-to-end testing will provide an ERA based on current year pricing.

How many claims can testers submit?
There is no limit on the number of acknowledgement test claims you can submit.

You may submit 50 end-to-end test claims per test week.

How do testers submit claims for testing?
You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator “T” in the Interchange Control Structure (ISA) 15 field.

You submit end-to-end test claims directly with test indicator “T” in the ISA15 field or through DDE.

When should testers submit test claims?
You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks:
- March 2 – 6, 2015; and
- June 1 – 5, 2015.

You must submit end-to-end test claims during the following testing weeks:
- January 26 – 30, 2015;
- April 27 – May 1, 2015; and

What dates of service do testers use during testing?
You must use current dates of service during acknowledgement testing.

You must use the following future dates of service during end-to-end testing:
- Professional claims – Dates of service on or after October 1, 2015;
- Inpatient claims – Discharge dates on or after October 1, 2015; and Supplier claims – Dates of service between October 1, 2015, and October 15, 2015; and
- Professional and institutional claims – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

**Important Note:** Remember that you must be selected by the MAC in order to participate in end-to-end testing.

**RESOURCES**
The chart below provides ICD-10 resource information.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10</td>
<td>For More Information About...</td>
</tr>
</tbody>
</table>
service on or after 12/03/2014)

- **Revised**: Standard Documentation Language to add covered prior to a beneficiary’s Medicare eligibility

**HCPCS CODES AND MODIFIERS:**
- **Added**: Codes A4602 and J2274
- **Deleted**: Codes J2271 and J2275

**ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:**

**Group 4 Paragraph:**
- **Added**: HCPCS Code for Levodopa-Carbidopa enteral suspension

**Group 4 Codes:**
- **Added**: ICD-9 Code 332.0

**Group 5 Paragraph:**
- **Added**: HCPCS Code for Blinatumomab

**Group 5 Codes:**
- **Added**: ICD-9 Code 204.02

**DOCUMENTATION REQUIREMENTS:**
- **Revised**: Standard Documentation Language to add who can enter date of delivery date on the POD
- **Added**: Instructions for equipment retained from a prior payer
- **Added**: Repair /Replacement section

**Policy Article**
Revision Effective Date: 01/01/2015

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**
- **Removed**: “When required by state law” from ACA new prescription requirements
- **Revised**: Face-to-Face Requirements for treating practitioner

**CODING GUIDELINES:**
- **Added**: Coding requirements for lithium batteries
- **Deleted**: References to codes J2271 and J2275
- **Added**: Levodopa-Carbidopa enteral suspension (effective for dates of service on or after 01/09/2015)
- **Added**: Blinatumomab (effective for dates of service on or after 12/03/2014)

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

Provider Outreach and Education is currently developing additional education on policy changes. We will issue a ListServ message as soon as the education is available.
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

● **Revised:** HCPCS Narrative for E0986 and updated standard language documentation

Refractive Lenses

LCD


Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

● **Revised:** Standard Documentation Language regarding Medicare coverage

HCPCS CODING:

● **Revised:** HCPCS V2799 Narrative

DOCUMENTATION REQUIREMENTS:

● **Revised:** Standard Documentation Language to add who can enter date of delivery date on the POD

● **Added:** Continued Need, Continued Use, and Repair/Replacement

● **Revised:** Changed ICD-9 reference to diagnosis

Policy Article


Revision Effective Date: 05/01/2013 (February 2015 Publication)

● **Removed:** Reference to ICD-9 located in the narrative

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

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

**Miscellaneous**

Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15


MLN Matters® Number: MM8901

Related Change Request (CR) #: CR 8901

Related CR Release Date: December 12, 2014

Effective Date: March 18, 2015

Related CR Transmittal #: R561PI

Implementation Date: March 18, 2015

**Provider Types Affected**

This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**What You Need to Know**

Change Request (CR) 8901 incorporates into Chapter 15 of the “Program Integrity Manual” (PIM) several provider enrollment policies in the final rule titled, “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs.”

**Key Points of CR8901**

The key points of the updated Chapter 15 of the “Medicare Program Integrity Manual” are as follows:

● If a MAC approves a provider’s or supplier’s Form CMS-855 reactivation application or Reactivation Certification Package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new Provider Transaction Access Number (PTAN).

● CMS may deny a physician’s or eligible professional’s Form
CMS-855 enrollment application under § 424.530(a)(11) if:

- The physician’s or eligible professional’s Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
- The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional’s ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(13) if:

- The physician’s or eligible professional’s DEA Certificate of Registration is suspended or revoked; or
- The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional’s ability to prescribe drugs.

CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:

- The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
- The pattern or practice of prescribing fails to meet Medicare requirements.

Additional Information


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

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2015


MLN Matters® Number: MM8982
Related Change Request (CR) #: CR 8982
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R89GI
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new Calendar Year (CY) 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of
Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

### 2015 PART A - HOSPITAL INSURANCE (HI)

- **Deductible:** $1,260.00
- **Coinsurance**
  - $315.00 a day for 61st-90th day
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $407.00 a month
- **BP with 10% surcharge:** $447.70 a month
- **BP with 45% reduction:** $224.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45% reduction and 10% surcharge:** $246.40 a month

### 2015 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- **Standard Premium:** $104.90 a month
- **Deductible:** $147.00 a year
- **Pro Rata Data Amount**
  - $114.99 1st month
  - $32.01 2nd month
- **Coinsurance:** 20 percent

#### Additional Information


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

#### 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:** MM8983
**Related Change Request (CR) #:** CR 8983
**Related CR Release Date:** November 26, 2014
**Effective Date:** April 1, 2015
**Related CR Transmittal #:** R3135CP
**Implementation Date:** April 6, 2015

#### Provider Types Affected

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

#### Provider Action Needed

Change Request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of
CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2015, and CR8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.


Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of the Department of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

Note: Per Affordable Care Act mandate, all health plans, including Medicare, must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined Business Scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work?
specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the on Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9004, MACs will implement on the date specified on the WPC website. The WPC website is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

CR9004 lists only the changes that have been approved since the last code update CR (CR8855, Transmittal 2996, issued on July 25, 2014, with a related MLN Matters® article available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

**Changes in CARC List since CR8855**

These are changes in the CARC database since the last code update in CR8855.

### New Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>262</td>
<td>Adjustment for delivery cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>263</td>
<td>Adjustment for shipping cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>264</td>
<td>Adjustment for postage cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>265</td>
<td>Adjustment for administrative cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>266</td>
<td>Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</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>133</td>
<td>The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>201</td>
<td>Patient is responsible for amount of this claim/service through ‘set aside arrangement’ or other agreement. (Use only with Group Code PR) 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.)</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

### Deactivated Codes – CARC

None

**Changes in RARC List since CR8855**

These are changes in the RARC database since the last code update CR 8855.

### New Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N729</td>
<td>Missing patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N730</td>
<td>Incomplete/invalid patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N731</td>
<td>Incomplete/invalid mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N732</td>
<td>Services performed at an unlicensed facility are not reimbursable.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N733</td>
<td>Regulatory surcharges are paid directly to the state.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N734</td>
<td>The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

### Modified Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N42</td>
<td>Missing mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>MA118</td>
<td>Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>
Deactivated Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N483</td>
<td>Missing Periodontal Charts</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N484</td>
<td>Incomplete/invalid Periodontal Charts</td>
<td>5/1/2015</td>
</tr>
</tbody>
</table>

NOTE: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional Information


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

Revised Centers for Medicare & Medicaid Services (CMS) 855R Application - Reassignment of Medicare Benefits


MLN Matters® Number: SE1432
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: June 1, 2015
Related CR Transmittal #: N/A
Implementation Date: May 31, 2015

Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

Provider Action Needed

STOP — Impact to You

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R (Reassignment of Benefits) application beginning June 1, 2015.

CAUTION — What You Need to Know

The revised CMS 855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015, after which the revised CMS 855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

GO — What You Need to Do

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

Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R application starting June 1, 2015. The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity. The revised form includes an optional section for primary practice location address. This information is shared with other programs such as Physician Compare to help beneficiaries identify where their physicians are primarily practicing. This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

Additional Information

Visit the Medicare Provider Supplier Enrollment webpage for more information about Medicare enrollment, available at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html) on the CMS website.
Fees & Pricing

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


MLN Matters® Number: MM8865 Revised

Related Change Request (CR) #: CR 8865

Related CR Release Date: November 13, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R3123CP

Implementation Date: October 6, 2014

Note: This article was revised on November 17, 2014, to reflect the revised CR8865 issued on November 13. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/

Key Points of CR8865

Splints, Casts, and Certain Intraocular Lenses (IOLs)

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

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

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

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

Off-the-Shelf (OTS) Orthotics

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

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

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

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

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

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

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

Additional Information


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

Calendar Year (CY) 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule


MLN Matters® Number: MM8999
Related Change Request (CR) #: CR 8999
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3129CP
Implementation Date: January 5, 2015

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background
CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints,
casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

Key Points

Fee Schedule Files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.459</td>
<td>Oxygen</td>
</tr>
<tr>
<td>0.462</td>
<td>Capped Rental</td>
</tr>
<tr>
<td>0.464</td>
<td>Prosthetics and Orthotics</td>
</tr>
<tr>
<td>0.588</td>
<td>Surgical Dressings</td>
</tr>
<tr>
<td>0.640</td>
<td>Parenteral and Enteral Nutrition</td>
</tr>
<tr>
<td>0.963</td>
<td>Intraocular Lenses</td>
</tr>
<tr>
<td>0.980</td>
<td>Splints and Casts</td>
</tr>
</tbody>
</table>

Specific Coding and Pricing Issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.


Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing
bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5% for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

2015 Fee Schedule Update Factor of 1.5 Percent

For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 Update to the Labor Payment Rates

The table below contains the CY 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for CY 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>$27.98</td>
<td>$31.88</td>
<td>$37.50</td>
</tr>
<tr>
<td>AL</td>
<td>14.86</td>
<td>22.14</td>
<td>30.05</td>
</tr>
<tr>
<td>AR</td>
<td>14.86</td>
<td>22.14</td>
<td>30.05</td>
</tr>
<tr>
<td>AZ</td>
<td>18.37</td>
<td>22.11</td>
<td>36.97</td>
</tr>
<tr>
<td>CA</td>
<td>22.79</td>
<td>36.34</td>
<td>42.35</td>
</tr>
<tr>
<td>CO</td>
<td>14.86</td>
<td>22.14</td>
<td>30.05</td>
</tr>
<tr>
<td>CT</td>
<td>24.81</td>
<td>22.63</td>
<td>30.05</td>
</tr>
<tr>
<td>DC</td>
<td>14.86</td>
<td>22.11</td>
<td>30.05</td>
</tr>
</tbody>
</table>
2015 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of CR8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment


To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to Change Request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional Information


If you have questions please contact your MAC at their toll-free number. The number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work?
April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files


MLN Matters® Number: MM9084
Related Change Request (CR) #: CR 9084
Related CR Release Date: January 30, 2015
Effective Date: Effective Date: April 1, 2015
Related CR Transmittal #: R3180CP
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

Background

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

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/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>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
<tr>
<td>October 2014 ASP and ASP NOC</td>
<td>October 1, 2014, through December 31, 2014</td>
</tr>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
</tr>
<tr>
<td>April 2014 ASP and ASP NOC</td>
<td>April 1, 2014, through June 30, 2014</td>
</tr>
</tbody>
</table>

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

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
The 2015 HCPCS Updates – New, Revised, and Discontinued HCPCS Codes

The 2015 Healthcare Common Procedure Coding System (HCPCS) File has been published. There are several additions, revisions, and discontinued HCPCS codes. The changes are effective January 1, 2015. Please keep in mind, the appearance of a HCPCS code is not an indication of coverage by the DME MAC.

The first listing contains the added HCPCS Codes that will take effect on January 01, 2015.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4459</td>
<td>Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type</td>
</tr>
<tr>
<td>A4602</td>
<td>Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each</td>
</tr>
<tr>
<td>J0153</td>
<td>Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds)</td>
</tr>
<tr>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
</tr>
<tr>
<td>J0572</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg</td>
</tr>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg</td>
</tr>
<tr>
<td>J0574</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg</td>
</tr>
<tr>
<td>J0575</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg</td>
</tr>
<tr>
<td>J0888</td>
<td>Injection, epoetin beta, 1 microgram, (for non esrd use)</td>
</tr>
<tr>
<td>J1071</td>
<td>Injection, testosterone cypionate, 1mg</td>
</tr>
<tr>
<td>J1322</td>
<td>Injection, elosulfase alfa, 1mg</td>
</tr>
<tr>
<td>J1439</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
</tr>
<tr>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, propofol, 10 mg</td>
</tr>
<tr>
<td>J3121</td>
<td>Injection, testosterone enanthate, 1mg</td>
</tr>
<tr>
<td>J3145</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
</tr>
<tr>
<td>J9267</td>
<td>Injection, paclitaxel, 1 mg</td>
</tr>
<tr>
<td>J9301</td>
<td>Injection, obinutuzumab, 10 mg</td>
</tr>
<tr>
<td>L3981</td>
<td>Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments</td>
</tr>
<tr>
<td>L6026</td>
<td>Transcarpal/metakarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device</td>
</tr>
<tr>
<td>L7259</td>
<td>Electronic wrist rotator, any type</td>
</tr>
</tbody>
</table>

The listing of HCPCS Codes with description/verbiage changes that will take effect January 01, 2015 is as follows:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4601</td>
<td>Lithium ion battery, rechargeable, for non-prosthetic use, replacement</td>
</tr>
<tr>
<td>E0856</td>
<td>Cervical traction device, with inflatable air bladder(s)</td>
</tr>
<tr>
<td>E0986</td>
<td>Manual wheelchair accessory, push-rim activated power assist system</td>
</tr>
<tr>
<td>J7367</td>
<td>Lithium ion battery, rechargeable, replacement</td>
</tr>
<tr>
<td>V2799</td>
<td>Vision item or service, miscellaneous</td>
</tr>
</tbody>
</table>

The last listing contains discontinued HCPCS Codes along with the cross walked HCPCS Code (if applicable). However, not all discontinued HCPCS Codes will have a cross-walked HCPCS Code. The list is as follows:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DISCONTINUE DATE</th>
<th>CROSSWALK HCPCS CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7042</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>A7043</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J0150</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J0151</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J0900</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J1060</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J1070</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J1080</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J2271</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J2275</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J2274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J3120</td>
<td>12/31/2014</td>
<td></td>
</tr>
<tr>
<td>J3130</td>
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MLN Matters® Number: MM9018
Related Change Request (CR) #: CR 9018
Related CR Release Date: December 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3148CP
Implementation Date: January 5, 2015

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

Provider Action Needed
Change Request (CR) 9018 notifies suppliers that the spreadsheet containing an updated list of Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC or MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the “Medicare Claims Processing Manual” are reflected in the recurring update notification.

The spreadsheet for the 2015 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html on the Centers for Medicare & Medicaid Services (CMS) website. The spreadsheet is also attached to CR9018.

Additional Information

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

Competitive Bidding

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2015


MLN Matters® Number: MM8918
Related Change Request (CR) #: CR 8918
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3136CP
Implementation Date: April 6, 2015

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8918 to provide the DMEPOS Competitive Bidding Program (CBP) April 2015 quarterly update. CR 8918 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background
The DMEPOS Competitive Bidding Program was mandated
by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier’s eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

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.

Additional Information


There are 14 separate products on pages four through six in the MLN Catalogue of Products at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mlncatalog.pdf that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

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

News Flash Items
From MLN Matters Articles:

(MM8566 Revised)
REVISED products from the Medicare Learning Network (MLN)


(MM8844)
REVISED product from the Medicare Learning Network® (MLN)


(MM8994)
REVISED product from the Medicare Learning Network® (MLN)


(MM8867)
Subscribe to the MLN Connects™ Provider eNews: a weekly electronic publication with the latest Medicare program information, including MLN Connects™ National Provider Call announcements, claim and pricer information, and Medicare Learning Network® educational product updates. (https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819)

NEW product from the Medicare Learning Network® (MLN)


Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf) and MLN Matters® Article SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1431.pdf).

While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder (http://vaccine.healthmap.org/) is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register (http://vaccine.healthmap.org/admin/signup/) for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) (http://www.cdc.gov/FLU/) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

Raising Awareness of Diabetes in November - During the month of November, the United States draws attention to diabetes and its impact on public health through several national health observances, including National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day. Millions of Americans have diabetes and don’t know it. Left undiagnosed or untreated, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney disease, amputation, and even premature death. Read more to learn about the preventive services covered by Medicare that focus on early disease detection and disease management. (http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Health-Observance-Messages-New-Items/2014-11-02-World-Diabetes-Day.html?DLPage=1&DLSort=0&DLSortDir=descending)

Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit – a yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the “Welcome to Medicare” Preventive Visit – a one-time service for newly-enrolled beneficiaries. Read more. (http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Health-Observance-Messages-New-Items/2015-01-08-AWV-IPPE.html?DLPage=1&DLSort=0&DLSortDir=descending)

Recognizing Lung Cancer Awareness Month and the Great American Smokeout November is Lung Cancer Awareness Month and November 20 is the Great American Smokeout. Lung cancer is the leading cause of cancer death in the United States for both men and women. Cigarette smoking is the number one cause of lung cancer. Almost 1 in 5 Americans smokes cigarettes, and tens of thousands more smoke pipes or cigars, which also cause lung cancer. Many smokers who want to quit have great difficulty succeeding. As a provider of health care services to people with Medicare, you can provide support to seniors who want to quit tobacco use, and

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<td>Fax (for underpayments): 1.615.782.4649</td>
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