THE DME MAC JURISDICTION C

INSIDER

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CGS®
A CELERIAN GROUP COMPANY

CMS
# CGS DME MAC Jurisdiction C INSIDER

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“Can’t We All Just Get Along?”

The folks that have heard me speak to suppliers and physicians know that I like to promote two things: A “Neighborhood Watch” mentality when it comes to DME fraud and what’s happening in your industry and a collaborative approach to dealing with physicians and education. Both of these ideas recently were brought to mind this past week. The first, when a fraud investigator contacted me about a case, based on a tip from a DME supplier. The second, when I shot a new Medicare Minute video specifically targeted to physicians.

As many of you have seen, I’ve been doing Medicare Minute videos for a couple of years. Most are 2-3 minutes in length and focus on different DME policies and issues. The most recent addition to our collection was suggested by a DME supplier. They asked that I produce a video directed at physicians who prescribe power mobility devices. Even better they said, can the video be made available in all four DME MAC jurisdictions? So based on our DME MAC “Dear Physician” letter, I produced a 4-5 minute Medicare Minute video that covers the key points that physicians need to know when prescribing power mobility devices and shared it with the other DME MAC contractors.

For CGS users the video is available on our website or through our mobile app. Physicians can access the information in video format, audio-only podcast or they can go “old school” and view the “Dear Physician” letter. We’re giving you choices and working together, we can help get your claims paid correctly. The first time. Every time.

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director
DME MAC Jurisdiction C
myCGS

myCGS Now Includes Prior Authorization and ADMC Status!

The myCGS web portal (http://www.cgsmedicare.com/jc/mycgs/index.html) was recently updated to include Prior Authorization (http://www.cgsmedicare.com/jc/mr/prior_auth.html) and Advance Determination of Medicare Coverage (ADMC) (http://www.cgsmedicare.com/jc/mr/ADMC.html) status. To access the new Prior Authorization/ADMC status screen, log in to myCGS and follow these steps:

1. Go to the Claim Preparation tab.
2. Select the Prior Authorization secondary tab.
3. Enter the HICN, beneficiary name (last and first), beneficiary date of birth, and HCPCS code from the detailed product description (DPD) of the Prior Authorization or ADMC request, then press Submit.
4. myCGS will then display information about any matching Prior Authorization/ADMC request on file with Jurisdiction C, including the following fields:
   - **Status**: The current status of the Prior Authorization/ADMC request (either complete or pending).
   - **Date of Receipt**: The date in which we received the Prior Authorization/ADMC request.
   - **Date of Decision**: The date in which the Prior Authorization/ADMC decision was made.
   - **Action Taken**: The Prior Authorization/ADMC decision; either “Affirmed” or “Non-Affirmed” or “Pending.”
   - **Denial Reason**: The reason why a Prior Authorization request was “Non-Affirmed” (if applicable; note that this field will be blank for ADMC requests).
   - **UTN**: The Unique Tracking Number of the Prior Authorization request. Please note the UTN is not used for ADMC requests.


Future myCGS Updates

We are continuously working to make myCGS better and better and have big things planned for 2015! Be the first to know about new myCGS features by subscribing to our ListServ email (http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp).

We Want Your Feedback

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 web survey (http://www.cgsmedicare.com/jc/education/video/foresee.html).

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!
News from the Inside

The Importance of Social Media and Medicare Education

By: Melissa Kirchenbauer, Assistant Vice President/Operations Director Jurisdiction C DME MAC

Use of “social media” has evolved since we were first introduced to services such as “Friendster” and “MySpace” over 10 years ago. Today, many people use social media sites for much more than just staying in touch with friends and family. Sites such as Facebook, Twitter, and Instagram now serve as direct lines of communication for many businesses — allowing them to instantaneously reach their customers and their employees with important news, information, and education.

Results from a recent survey of suppliers across Jurisdiction C, show an increase in the number of Jurisdiction C suppliers and their staff who use social media sites for business-related information. We have also seen an increase in the use of mobile devices such as tablets and phones that access social media sites during normal business hours. That is why CGS is expanding our use of popular social media sites to share information and education with customers throughout Jurisdiction C.

CGS has implemented several changes to how we now use social media for DME suppliers. As our fans and followers continue to increase, CGS is offering a wider variety of information and education opportunities available through our Facebook and Twitter channels. And, we’ve made it possible for all of our social media sites to be interactive. As we post important information, we want your comments. We want you to share information you think is beneficial for your peers. We want to keep the “social” in social media so you always have an opportunity to share your comments.

Our posts to social media are not just re-directs to content on our website. We publish information you can access and use immediately to supplement your office education needs. Each day, CGS issues a variety of information beneficial to DME suppliers. We have added video and podcasts so you can get instant information from your office PC or mobile device. Information that is relevant to you…today!

We are very excited about how we can use social media to increase your access to important Jurisdiction C information and education! If you don’t currently use social media, we would encourage you to sign up and join the growing number of Jurisdiction C suppliers who now rely on these sites for Medicare information.

MR WIZARD Lets You Span Dates for Medical Review Denials and Information

Our popular MR WIZARD Medical Review denial tool now provides you with the ability to view ALL Medical Review decisions including Claim Control Numbers (CCNs) within a specified date range and export them to an Excel spreadsheet. This helps suppliers who wish to view multiple CCNs without having to enter each one separately.

To use our new data range and export features, go to the MR WIZARD tool located under the Medicare Review and Online Tools menus. Go to the “Search for all CCNs within a specific date range form. Enter your NPI and the start and end date range. When you press submit, MR WIZARD will return a complete list of all medical review denials within that date range. You may then export the file follow our easy on screen instructions.

MR WIZARD provides the most detailed online medical review denial information available….anywhere!
New Supplier Welcome Center

Provider Outreach and Education has created the New Supplier Welcome Center to help new suppliers start their journey to enrolling in Medicare, understanding the program, and filing a compliant and accurate Medicare claim.

The New Supplier Welcome Center provides links to in-depth information, including a checklist to help navigate enrollment information, suggested education, website navigation, tips for patient intake and claim submission information.

The New Supplier Welcome Center is accessed through the Education link on the CGS website at the following URL: http://www.cgsmedicare.com/jc/education/nswc.html

The following checklist is also included in the New Supplier Welcome Center:

**New Supplier Checklist**

### Enroll, Enroll and Register:

- Apply for a National Provider Identifier (NPI)
  
  [Visit this site](https://nppes.cms.hhs.gov/NPPES/Welcome.do)

- Submit a Medicare enrollment application and Electronic Fund Transfer (EFT) form to the National Supplier Clearinghouse (NSC)
  
  [Visit this site](http://www.palmettogba.com/nsc)

- Complete forms for electronic transactions (claim submission, remittance advice) with CEDI
  
  [Visit this site](http://www.ngscedi.com/ngs/portal/ngscedi/!ut/p/a0/04_Sj9CPykssy0xP/LMnMz0vMAfGjzOK9DS1NPP29DbwsggOdDRz9PbwDjAzdjAx8zfQLsh0VAVCKRgc/)

- Register for myCGS – The Jurisdiction C Web portal to check patient eligibility, claim status, claim denial information and much more
  
  [Visit this site](http://www.cgsmedicare.com/jc/mycgs/index.html)

- Subscribe to the listserv DME MAC Jurisdiction C News email subscription
  
  [Visit this site](http://www.cgsmedicare.com/jc/forms/pdf/jc_suggested_intake_form.pdf)

### Jurisdiction C Website Navigation

Take a video tour of the website to learn how to find contact information, forms and self service tools:

- Website Tutorial
  
  [Visit this site](http://www.cgsmedicare.com/jc/education/video/tutorial.html)

### Patient Intake

Make sure all information and documentation required for claim submission is collected:

- Suggested Intake Form
  
  [Visit this site](http://www.cgsmedicare.com/jc/forms/pdf/jc_suggested_intake_form.pdf)

- Medicare Secondary Payer (MSP) Lookup Tool
  
  [Visit this site](http://www.cgsmedicare.com/jc/claims/msp_tool.html#tool)

- Documentation Checklists
  
  [Visit this site](http://www.cgsmedicare.com/jc/mr/DocumentationChecklists.html)

- Dear Physician Letters – Documentation Requirements
  
  [Visit this site](http://www.cgsmedicare.com/jc/mr/Doc_Req.html)

### Claim Submission

Review information about how to submit your claim:

- Submitting a Claim Web Page
  
  [Visit this site](http://www.cgsmedicare.com/jc/claims/sub/index.html)

- Interactive Claim Form Instructions
  
  [Visit this site](http://www.cgsmedicare.com/jc/help/1500_Claim_Form.swf)

### Where to go for help

For claim specific assistance:

- Customer Service
  
  [Visit this site](http://www.cgsmedicare.com/jc/cs/index.html)

For education on policies and guidelines:

- Community Coach Program
  
  [Visit this site](http://www.cgsmedicare.com/jc/education/ccp.html)
We’ve added a lot to myCGS in 2014, thanks in large part to the suggestions and feedback that you, the users, have given us.

- Claim History
- Reopening Status
- Prior Authorization
- Referring Physician Details
- Remittance Advice Details

These are just some of the things we’ve implemented based on your suggestions. Stay tuned—We’ve got even bigger things planned for 2015!
Palatal Lift Prosthesis - Correct Coding  
- Joint DME MAC Publication

A palatal lift prosthesis is a dental appliance that is used to support the soft palate in individuals lacking the normal muscle function necessary to maintain the soft palate in its normal position.

Claims are occasionally submitted to the DME MACs using Not Otherwise Classified (NOC) HCPCS codes. When a specific code exists for any item, use of a NOC code is incorrect coding. The specific codes to be used on claims for a palatal prosthesis are:

- D5955 - Palatal lift prosthesis, definitive
- D5958 - Palatal lift prosthesis, interim
- D5959 - Palatal lift prosthesis, modification

Current Dental Terminology (CDT) D codes are not within DME MAC jurisdiction. Claims for D codes must be submitted to the local carrier and should not be submitted to the DME MAC.

Claims for palatal lift prostheses must not be submitted to the DME MAC using HCPCS NOC (Not Otherwise Classified) codes.

ICD-10 Updates to Local Coverage Determinations (LCDs) and Policy Articles (PAs) - Updated

Originally Published April 10, 2014  
Updated September 25, 2014

As promised in our March 20, 2014 publication, all LCDs ([http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=140&ContrVer=2&CntrctrSelected=140*2&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&DocType=Future&bc=AgACAAAAAAAA%3d%3d&#ResultsAnchor](http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=140&ContrVer=2&CntrctrSelected=140*2&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&DocType=Future&bc=AgACAAAAAAAA%3d%3d&#ResultsAnchor)) and related PAs ([http://www.cms.gov/medicare-coverage-database/indexes/article-list.aspx?Cntrctr=140&name=CGS%20Administrators,%20LLC%20(18003,%20DME%20MAC)&DocStatus=Future&ContrVer=2&CntrctrSelected=140*2&LCntrctr=140*2&bc=AgABAAEAAAAAAAA%3d%3d&#ResultsAnchor](http://www.cms.gov/medicare-coverage-database/indexes/article-list.aspx?Cntrctr=140&name=CGS%20Administrators,%20LLC%20(18003,%20DME%20MAC)&DocStatus=Future&ContrVer=2&CntrctrSelected=140*2&LCntrctr=140*2&bc=AgABAAEAAAAAAAA%3d%3d&#ResultsAnchor)) have been updated and are included in the Medicare Coverage Database. To keep separate the ICD-9s from the ICD-10s, all ICD-10 LCDs and PAs (with and without diagnosis codes) have been assigned new ID numbers.

The Centers for Medicare & Medicaid (CMS) has determined that although new LCD numbers are assigned, the policies shall not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD.

For more information, CMS has dedicated a page to ICD-10 at [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html). This page is updated regularly, usually at least once per week, and houses resources, articles and products concerning ICD-10. Suppliers can check the latest news specific to ICD-10 as well as reference applicable Medicare Learning Network (MLN) publications.

The following list of LCDs and related PAs contains diagnoses that have been updated to ICD-10 codes:

<table>
<thead>
<tr>
<th>LCD Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33686</td>
<td>Ankle-Foot/Knee-Ankle-Foot Orthosis</td>
</tr>
<tr>
<td>L33690</td>
<td>Automatic External Defibrillators</td>
</tr>
<tr>
<td>L33317</td>
<td>External Breast Prostheses</td>
</tr>
<tr>
<td>L33794</td>
<td>External Infusion Pumps</td>
</tr>
<tr>
<td>L33822</td>
<td>Glucose Monitors</td>
</tr>
<tr>
<td>L33785</td>
<td>High Frequency Chest Wall Oscillation Devices</td>
</tr>
<tr>
<td>A25474</td>
<td>Immunosuppressive Drugs - Policy Article</td>
</tr>
<tr>
<td>A52509</td>
<td>Intravenous Immune Globulin - Policy Article</td>
</tr>
<tr>
<td>L33803</td>
<td>Urological Supplies</td>
</tr>
<tr>
<td>L33611</td>
<td>Oral Appliances for Obstructive Sleep Apnea</td>
</tr>
<tr>
<td>L33641</td>
<td>Orthopedic Footwear</td>
</tr>
</tbody>
</table>
Cefaly® - Correct Coding
- Joint DME MAC Publication

The Cefaly® device (Cefaly Technology) is a transcutaneous electrical nerve stimulator (TENS) that is applied to the forehead using a self-adhesive electrode positioned bilaterally over the upper branches of the trigeminal nerve. The Cefaly® device is intended to stimulate the upper branches of the trigeminal nerve and has received Food and Drug Administration (FDA) approval for the prophylactic treatment of episodic migraine headache.

Items that serve a prevention or precautionary purpose are non-covered by Medicare. The correct code for Cefaly® is:

A9270 – Noncovered item or service.

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

Negative Pressure Wound Therapy Devices (NPWT) - Coverage Reminder - Revised – October 2, 2014
- Joint DME MAC Publication

**Note:** This is a revision to a previous version published September 4, 2014. It corrects an error in the “Prescriptions” requirement section that incorrectly referenced the Affordable Care Act (ACA) §6407 requirement for HCPCS code E2402. The ACA requirements do not apply to code E2402; however, code E2402 does require a written order prior to delivery.

A recent examination of CERT reviews for NPWT 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**

- Prescription Related
  - Referring physician’s detailed written order missing - 9.09%

**PAYMENT RULES**

**Prescriptions:**

All items billed to Medicare require a prescription. NPWT base code E2402 (NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE) requires that the prescription must meet the Written Order Prior to Delivery requirements.

**Reasonable and Necessary (R&N) Criteria:**

NPWT is only covered for certain types of wounds when other treatments have failed. The LCD specifies the following:

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met:

**A. Ulcers and Wounds in the Home Setting:**

The beneficiary has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
   - Documentation in the beneficiary’s medical record of evaluation, care, and wound measurements by a licensed medical professional, and
   - Application of dressings to maintain a moist wound environment, and
   - Debridement of necrotic tissue if present, and.
d. Evaluation of and provision for adequate nutritional status

2. For Stage III or IV pressure ulcers:
   a. The beneficiary has been appropriately turned and positioned, and
   b. The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and
   c. The beneficiary’s moisture and incontinence have been appropriately managed

3. For neuropathic (for example, diabetic) ulcers:
   a. The beneficiary has been on a comprehensive diabetic management program, and
   b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

4. For venous insufficiency ulcers:
   a. Compression bandages and/or garments have been consistently applied, and
   b. Leg elevation and ambulation have been encouraged

B. Ulcers and Wounds Encountered in an Inpatient Setting:

1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.

2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

Coverage of NPWT ends when certain conditions occur. The LCD specifies:

C. For wounds and ulcers described under A or B above, once placed on an NPWT pump and supplies, in order for coverage to continue, a licensed medical professional must do the following:

1. On a regular basis,
   a. Directly assess the wound(s) being treated with the NPWT pump, and
   b. Supervise or directly perform the NPWT dressing changes, and

2. On at least a monthly basis, document changes in the ulcer’s dimensions and characteristics.

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.

Durable Medical Equipment Provided During a Part A Stay:

Durable Medical Equipment (DME) is only covered when provided for use in the beneficiary’s home. DME provided during a covered Part A stay is not eligible for separate reimbursement by the DME MACs.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. There are additional requirements necessary for coverage that are not discussed. Refer to the LCD and related Policy article for complete information. Further education regarding this policy is available on your DME MAC contractor website.

Referenced Information:

DME MAC Jurisdiction C
(http://www.cgsmedicare.com/jc/index.html)
Negative Pressure Wound Therapy Pumps (L5008)
Negative Pressure Wound Therapy Pumps – Policy Article (A35363)
Pressure Reducing Support Surfaces - Group 2 (L11564)
(http://www.cms.gov/medicare-coverage-database/details/lcd-
ACRA Requirement for Indicating Receipt Date of Documentation

- Joint DME MAC Article

With the implementation of Affordable Care Act (ACA) Section 6407, there are local coverage determinations (LCDs) and related policy articles (PAs) that require suppliers to receive clinical documentation and orders within a specific period of time. According to these LCDs, “A date stamp or equivalent must be used to document receipt date.” Documentation of the receipt date is a key requirement of these policies to demonstrate compliance with the statutory timeliness requirement.

Questions have arisen from suppliers about what methods are acceptable for documenting a receipt date. The DME MACs do not specify what method may be used to indicate date of receipt; however, there must be some indicator or notation on the documents that they were received by the supplier within the required time period. Some commonly accepted methods are hard-copy date stamps, handwritten dates, facsimile headers and electronic receipt dates. Regardless of the method used, it must be clear to contractor staff reviewing the claim that the date received meets the requirements in the applicable LCD.

A cautionary note about utilizing facsimile headers to document receipt date.

Suppliers often rely on a fax header that includes a date and time indicator as an alternative to a date stamp. However, there are often multiple facsimile header lines that are the result of documents being faxed back and forth between the supplier and treating physician. Consequently, it is often difficult to determine the actual date of receipt of the documents by the supplier.

Suppliers should review their process for documenting the date of receipt of the documentation related to policies that require a receipt date. Suppliers must ensure that all documents clearly indicate the date that the documents were received. Suppliers who rely on fax header information should be especially vigilant to make sure that the receipt date is clearly indicated to avoid claim denials.

Oral Anticancer Drugs and PDAC’s NDC/HCPCS Crosswalk Listings - Correct Coding

- Joint DME MAC Publication

Occasionally pharmaceutical manufacturers release drugs with NDCs and they do not immediately appear on the NDC/HCPCS crosswalk list maintained by the Pricing, Data Analysis and Coding (PDAC) contractor (see article from April 12, 2013 entitled “Oral Anticancer Drugs – Coding and Billing Change” (http://www.cgsmedicare.com/jc/pubs/news/2013/0413/cope21907.html)). This recently happened when Roxane Laboratories, Inc., a manufacturer of oral cyclophosphamide, discontinued their tablet forms of the drug and substituted capsules. Initially the capsule forms of the drug (NDC 00054-0382-25 for the 25 mg strength and NDC 00054-0383-25 for the 50 mg strength) were not on the NDC/HCPCS crosswalk list. This list has now been updated to reflect the new dosage forms and NDC numbers for Roxane’s cyclophosphamide.

If a supplier bills an oral anticancer drug with an NDC number that is not on the NDC/HCPCS crosswalk list, the claim will receive a front-end reject by CEDI. To avoid this situation, suppliers should follow the instructions in the Coding Guidelines section of the Oral Anticancer Drugs related Policy Article (PA) which states:

A list of valid NDC numbers called the “NDC/HCPCS Crosswalk” for covered oral anticancer drugs can be found on the Pricing, Data Analysis and Coding (PDAC) Contractor website. Until a new NDC number is added to the list, suppliers must submit claims using code J8999.

Until a new NDC number is added to the list in the monthly update, suppliers have two options:

1. Hold claim submission until the NDC/HCPCS Crosswalk reflects the monthly update of covered OACDs; or,
2. Submit claims using code J8999.

Claims submitted using code J8999 must include the name of the drug, the manufacturer, the NDC number, the dosage strength of each drug form (e.g., capsule, tablet, suppository, liquid) and the number of tablets or capsules dispensed. 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.
The NDC/HCPCS Crosswalk files can be found on the PDAC website at https://www.dmepdac.com/crosswalk/index.html

Standard Documentation Language for Local Coverage Determinations and Related Policy Articles – Revised

- Joint DME MAC Publication

Note: This is a revision to a previously article published February 17, 2012 and again September 2014 entitled Standard Documentation Language for Local Coverage Determinations and related Policy Articles – Revised. This version adds information on repairs in the Policy Specific Documentation Section of the LCDs.

Due to the length of the article, a link is provided for you to visit the article on the CGS website:


E1825, E1830 and E1831 and Use of Modifiers

- Joint DME MAC Publication

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS code E1825 (Dynamic adjustable finger extension/flexion device, includes soft interface material) must use one of the following modifiers when billing this code:

FA Left hand, thumb
F1 Left hand, second digit
F2 Left hand, third digit
F3 Left hand, fourth digit
F4 Left hand, fifth digit
F5 Right hand, thumb
F6 Right hand, second digit
F7 Right hand, third digit
F8 Right hand, fourth digit
F9 Right hand, fifth digit

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS Codes E1830 (Dynamic adjustable toe extension/flexion device, includes soft interface material) or E1831 (Static progressive stretch toe device, extension and/ or flexion, with or without range of motion adjustment, includes all components and accessories) must use one of the following modifiers when billing these codes:

TA Left foot, great toe
T1 Left foot, second digit
T2 Left foot, third digit
T3 Left foot, fourth digit
T4 Left foot, fifth digit
T5 Right foot, great toe
T6 Right foot, second digit
T7 Right foot, third digit
T8 Right foot, fourth digit
T9 Right foot, fifth digit

Failure to append a modifier to claim lines with codes E1825, E1830 or E1831 will result in a rejection for incorrect coding.

CMS 1500 Claim Form Instructions: Revised for Form Version 02/12


MLN Matters® Number: MM8509 Revised
Related Change Request (CR) #: CR 8509
Related CR Release Date: October 2, 2014
Effective Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10
Related CR Transmittal #: R3083CP
Implementation Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10

Note: This article was revised on October 6, 2014, to reflect the revised CR8509 issued on October 2. In the article, the effective and implementation dates have changed and the CR release date, transmittal number and the Web address for accessing the CR are changed. All other information is the same.

Provider Types Affected

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

Provider Action Needed

STOP — Impact to You

This change request (CR) 8509 revises the current CMS 1500 claim form instructions to reflect the revised CMS 1500 claim form, version 02/12.

CAUTION — What You Need to Know

Form Version 02/12 will replace the current CMS 1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

• Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
• Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
• On April 1, 2014, Medicare will accept paper claims on only the revised CMS 1500 claim form, 02/12; and
• On and after April 1, 2014, Medicare will no longer accept claims on the old CMS 1500 claim form, 08/05.

GO — What You Need to Do

Make sure that your billing staff are aware of these instructions for the revised form version 02/12.

Background

The National Uniform Claim Committee (NUCC) recently revised the CMS 1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

• DN - Referring Provider
• DK - Ordering Provider
• DQ - Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS 1500 claim form. Medicare therefore supports the implementation of the CMS 1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in Chapter 24 of the “Medicare Claims Processing Manual” which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.
Implement Operating Rules -
Phase III ERA EFT: CORE 360
Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - July 1, 2014 Version 3.1.1


MLN Matters® Number: MM8711 Revised
Related Change Request (CR) #: CR 8711
Related CR Release Date: August 8, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1418OTN
Implementation Date: September 2, 2014

Note: This article was revised on August 12, 2014, to reflect the revised CR8711 issued on August 8, 2014. The CR revised the CAQH CORE version number and the publication date. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. If you use Medicare’s PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (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.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary 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.

CAQH CORE will publish the next version of the Code Combination List on or about July 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.)

Note: Per the 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?
Non-Implantable Pelvic Floor Electrical Stimulation (PFES) – National Coverage Determination

Effective for dates of service on or after April 1, 2001, the Coverage Issues Manual (CIM) is being revised to permit coverage for non-implantable pelvic floor electrical stimulators. Reference to non-implantable pelvic floor electrical stimulators has been moved from CIM §65-9 (incontinence control devices) to CIM §60-24 (Non-Implantable Pelvic Floor Electrical Stimulator).

Section 60-24, Non-Implantable Pelvic Floor Electrical Stimulator, permits coverage for non-implantable pelvic floor electrical stimulators for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Suppliers submitting claims to the DMEMAC for PFES should use HCPCS code E0740 (Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer). This code is in the capped rental reimbursement category. Suppliers are reminded that there must be documentation in the patient’s medical record that the coverage criteria outlined in the national policy have been met. This documentation does not have to be routinely sent with the claim but must be available to the DMEMAC upon request.

Intravenous Immune Globulin (IVIG) Demonstration - Implementation


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

**Implementation Date:** N/A  
**Note:** This article was revised on August 28, 2014, to amend some of the billing instructions, particularly with regard to date of service on the Q2052 claim line. Also, some questions and answers related to supplier eligibility are added to the article.

**Provider Types Affected**

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services to Medicare beneficiaries.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

**Provider Action Needed**

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

**Background**

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

**IVIG Demonstration**

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

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

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

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

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

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

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

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

Beneficiary Eligibility

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

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

Billing Details

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

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

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

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.
The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim for the IVIG drug itself.

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

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

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

The following “J” codes (as updated by CR 8724) represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD:

- Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

**Note:** If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same place of service code on the claim line as the IVIG (J code) for which it is applicable. In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the “Q2052” claim line) may be no more than 30 calendar days after the date of service on the drug claim line.

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a Group Code of CO (Contractual Obligation), a Remittance Advice Remarks Code (RARC) of M51 (Missing/ incomplete/invalid procedure code(s)) and a Claim Adjustment Remarks Code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated).

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

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

**Questions and Answers Relating to Supplier Eligibility**

**Question:** Is the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

**Answer:** No. The DMEPOS supplier must currently be able to bill the DMEPOS supplier: Must be licensed to provide the nursing component of the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

**Question:** Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

**Answer:** Yes. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by State law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.
expressly prohibited by State law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other federal procurement or non-procurement programs.

**How Beneficiaries can apply for the IVIG Demonstration**

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. **Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.** CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS’ claims processing systems.

**CMS will conduct an initial enrollment period from 8/08/2014 – 9/12/2014. Completed applications must be received by NHIC, Corp. no later than 5:00 pm Eastern.**

**Time on 9/12/2014 to be considered.** Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by 9/30/2014 whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached.

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

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

**Applications may be mailed to:**

NHIC, Corp.

IVIG Demo

P.O. Box 9140

Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp

IVIG Demo

75 William Terry Dr.

Hingham, MA. 02043

Applications may be faxed to:

Fax 781-741-3533

**Additional Information**

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

**ICD-10**

**International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers**


**MLN Matters® Number:** MM8858

**Related Change Request (CR) #:** CR 8858

**Related CR Release Date:** August 22, 2014

**Effective Date:** 30 Days From Issuance (See test dates)

**Related CR Transmittal #:** R1423OTN

**Implementation Date:** November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week;

**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 (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries.
Provider Action Needed

Change Request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR8858 instructs all MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor to promote ICD-10 Acknowledgement Testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 – 21, 2014
- March 2 – 6, 2015
- June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners’ ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner’s access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC’s website.

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- 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 this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional Information


Medical Policy

LCD and Policy Article Revisions Summary for October 2, 2014

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

External Infusion Pumps

LCD


Revision Effective Date: 11/01/2014

DOCUMENTATION REQUIREMENTS:
- Removed: Suggested form for inotrope information

Knee Orthoses

LCD


Revision Effective Date: 10/01/2014

COVERAGE INDICATIONS, LIMITATIONS, and/or MEDICAL NECESSITY:
- Added: Codes K0901 and K0902 to Prefabricated Knee Orthoses section
- Added: Base Codes K0901 and K0902 to Addition Codes tables
- Added: Codes K0901 and K0902 to the requirement (1) for custom fabricated knee orthosis with an adjustable flexion and extension joint

HCPCS CODES:
- Added: Codes K0901 and K0902

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
- Added: Codes K0901 and K0902 to Group 4 Codes

Therapeutic Shoes for Persons with Diabetes

Policy Article


Revision Effective Date: 11/01/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Revised: Criterion 5 (in-person fitting requirement)

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

LCD and Policy Article Revision Summary for October 9, 2014

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

Respiratory Assist Devices

LCD


Revision Effective Date: 12/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
- Revised: Definitions of Central Sleep Apnea and Complex Sleep Apnea to include a CAHI index and expands signs and symptoms that describe the conditions
- Revised: Severe COPD to clarify that definitive testing is not necessary to exclude OSA when the clinical picture is sufficient
- Revised: Severe COPD to clarify that nocturnal oximetry is a
cumulative 5 minutes of testing
● Revised: Hypoventilation Syndromes to remove FEV1
● Revised: PSG testing to also include HST testing when used in the in-patient hospital setting to establish or rule out the diagnosis of OSA
● Added: Ventilator section based upon NCD and April 2014 coding and coverage article
● Added: Sleep Test coverage and payment rules

Policy Article
Revision Effective Date: 12/01/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
● Added: ACA 6407 prescriber requirements

Note: The information contained in this article is only a summary of revisions to the LCDs 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.

Pneumatic Compression Devices
LCD – Implementation Delayed
- Joint DME MAC Article

The Pneumatic Compression Devices Local Coverage Determination (LCD) and related Policy Article (PA) scheduled to take effect for dates of service on or after November 1, 2014 are being delayed. Additional clinical information published since the release of the draft policy is being reviewed. No future effective date for the draft policy is available at this time. The current LCD (http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5017&ContrId=140&Ver=38&ContrVer=2&CntntSelected=140*2&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&Lcntlcr=140*2&DocType=Active&bc=AgABAAEAAAAAAA%3d%3d) and related PA (http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=24141&ver=14&ContrId=140&ContrVer=2&CntntSelected=140*2&Cntntcr=140*2&Cntntcr=140*2&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&Lcntlcr=140*2&bc=AgABAAEAAAAAAA%3d%3d) will remain in effect.

Revised Modification to the Medically Unlikely Edit (MUE) Program


MLN Matters® Number: MM8853
Related Change Request (CR) #: CR 8853
Related CR Release Date: August 15, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1421OTN
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 Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 8853 informs MACs about additional modifications being updated in the Medically Unlikely Edit (MUE) Program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. At
that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. CR8853 contains current and updated background information for these modifications, including general processing instructions.

MUEs for HCPCS codes with a MAI of “1”

MUEs for HCPCS codes with a MAI of “1” will continue to be adjudicated as a claim line edit.

MUEs for HCPCS codes with a MAI of “2”

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for Current Procedural Terminology (CPT) 94002 “ventilation assist and management . . . initial day” because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

NOTE: Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with a MAI of 2 to be firm limits based on subregulatory guidance, while some MUE edits with an MAI “2” may be based directly on regulation or statute.

MUEs for HCPCS codes with a MAI of “3”

MUEs for HCPCS codes with a MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Processing Instructions

- Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.
- CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.
- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.
- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.” CMS interprets the notice delivery requirements under Section1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.
- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the “Medicare Claims Processing Manual” at http://www.cms.gov/Regulations-and-Guidance/
Guidance/Manuals/Downloads/clm104c34.pdf on the CMS website. Clerical errors (which includes minor errors and omissions) may be treated as reopenings.

- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.
- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- On your Remittance Advice, MACs will continue to use Group Code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

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.

Written Orders with Incomplete or Invalid Elements

CGS, DME MAC Jurisdiction C, Level I Appeals-Redeterminations Department continues to see written orders with incomplete or invalid elements. The DME MAC Jurisdiction C Supplier Manual, Chapter 3, (http://www.cgsmedicare.com/jc/pubs/pdf/chpt3.pdf) states that a detailed written order for items that are provided on a periodic or routine basis must include:

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

When billing routine supplies, the detailed written order should show the specific item with a specific per-day frequency and a total quantity billed for a refill cycle or period.

The physician order must include the following to meet this requirement. Note: each of these requires a number to satisfy the requirement:

- Frequency of use (amount per day)
- Quantity to dispense (total amount for each refill cycle)

Appeals

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

Please be aware that there is a change to the amounts that must remain in controversy for Administrative Law Judge (ALJ) hearing requests and Federal District Court review requests filed on or after January 1, 2015. The new amounts are reflected in the chart below.

<table>
<thead>
<tr>
<th>Appeal Level</th>
<th>Time Limit for Filing</th>
<th>Monetary Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination</td>
<td>120 days from the date of issuance of the initial determination or overpayment demand letter</td>
<td>None</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>180 days from the date of receipt of the Medicare Redetermination Notice</td>
<td>None</td>
</tr>
<tr>
<td>Administrative Law Judge (ALJ)</td>
<td>60 days from the date of receipt of the Reconsideration notice</td>
<td>For requests filed on or after January 1, 2015, at least $150 remains in controversy.</td>
</tr>
<tr>
<td>Departmental Appeals Board (DAB) Review</td>
<td>60 days from the date of receipt of the ALJ decision/dismissal</td>
<td>None</td>
</tr>
<tr>
<td>Federal Court (Judicial) Review</td>
<td>60 days from the date of the DAB decision or declaration of review by the DAB</td>
<td>For requests filed on or after January 1, 2015, at least $1,460 remains in controversy.</td>
</tr>
</tbody>
</table>
Number of refills

Both a frequency and a quantity must be included on the order with a description of each item. Frequency is how many times (amount per day) the item will be used on a daily basis. This can be expressed as an hourly frequency or as a daily frequency. It is important to have the physician indicate how many of the prescribed items the patient is to utilize each day. This helps to indicate how many units the patient should actually be prescribed in total for each refill cycle.

Quantity is the total amount of the item(s) that the physician prescribes for each refill cycle. The number of refills on the physician order can be expressed as a number of refills for a monthly fill cycle. The DME MAC also accepts “lifetime” or “99” in place of a monthly refill cycle amount. The frequency (amount per day) should be reflected in the quantity prescribed for each refill cycle. For example, if the frequency of use is 4 times per day and the refill cycle is 30 days then the quantity should be 120 units.

For more information on prescription requirements for a specific DME item, refer to the Local Coverage Determinations (LCD) for that item on the CGS website at: http://www.cgsmedicare.com/jc/coverage/lcdinfo.html

Level I-Redeterminations Filing Tips for Overpayments

To ensure clear, concise decisions and timely processing of Level I Redeterminations, please submit only one redetermination request per demand letter. You should include a copy of the demand letter and all supporting documentation (including but not limited to) all claims and other relevant information for the beneficiaries referenced in the letter you received.

For clear, concise decisions and timely processing, please submit one redetermination request including all claims and/or beneficiaries referenced in the demand letter received. Also, include the demand letter and supporting documentation with the request.

MLN Matters® Number: MM8506 Revised
Related Change Request (CR) #: CR 8506
Related CR Release Date: September 4, 2014
Effective Date: Upon ICD-10 Implementation
Related CR Transmittal #: R173NCD
Implementation Date: Upon ICD-10 Implementation

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8506 as an informational alert to providers that language-only changes—updates to the “Medicare National Coverage Determinations (NCD) Manual”, Pub 100-03—were made.

The changes were made to comply with:
1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

NOTE: The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.
Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Provider-Compliance-Interactive-Map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Provider-Compliance-Interactive-Map/index.html) on the CMS website.

Claim Status Category and Claim Status Codes Update


MLN Matters® Number: MM8735  
Related Change Request (CR) #: CR 8735  
Related CR Release Date: August 22, 2014  
Effective Date: January 1, 2015  
Related CR Transmittal #: R3043CP  
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 (HH&H MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8735 which informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure your billing staffs are aware of these changes.

Background

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

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 September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. 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 8735.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8735.

All MACs must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 Health Care Claim Acknowledgement Implementation Guide (inclusive of any published Errata documents) and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

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 Physician Specialty Code for Interventional Cardiology


MLN Matters® Number: MM8812 Revised
Related Change Request (CR) #: CR 8812
Related CR Release Date: September 23, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3073CP, R238FM
Implementation Date: January 5, 2015

Note: This article was revised on September 26, 2014, to reflect the revised CR8812 that was issued on September 23. 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, non-physician practitioners, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

CR 8812, from which this article is taken, provides notice that the Centers for Medicare & Medicaid Services (CMS) is establishing a new physician specialty code for Interventional Cardiology. The CR is also changing the description of specialty code 62, and updating the names associated to specialty codes 88 and 95. Make sure your billing staffs are aware of these changes.

Background

Physicians who enroll in the Medicare program self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Non-physician practitioners who enroll with Medicare are assigned a Medicare specialty code. These Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. They become associated with the claims that physician or non-physician practitioners submit; and are used by CMS for programmatic and claims processing purposes.

CR 8812 establishes a new physician specialty code for Interventional Cardiology (C3). CR8812 is also removing the word “Clinical” from the description of specialty code 62 (Psychologist (Billing Independently)), and is changing the description of specialty code 88 to “Unknown Provider,” and of specialty code 95 to “Unknown Supplier”. The changes to the descriptions for codes 88 and 95 align their names with their intended usages.

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.

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: MM8838
Related Change Request (CR) #: CR 8838
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3038CP
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8838 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 October 1, 2014. This update is based on July 1, 2014 CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

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 Patient Protection and Affordable Care Act of 2010. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary 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.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. 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.

Transitioning Medicare Administrative Contractor (MAC) Workloads to the New Banking Contractor(s)


MLN Matters® Number: MM 8847
Related Change Request (CR) #: CR 8847
Related CR Release Date: September 19, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R240FM
Implementation Date: September 30, 2014

Provider Types Affected

This MLN Matters® Article is intended to alert all providers that your Medicare Administrative Contractor (MAC) may be transitioning their banking to another bank.

What You Need to Know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two new five year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior
contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these new contracts on July 10, 2014. Change Request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

**Background**

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase); these two banks disburse MAC authorized payments and Demonstration project payments for CMS. The two current commercial banking contracts are terminating in Fiscal Year 2015. CMS has awarded new five year contracts through full and open competition to US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and Demonstration payment services and shall be designated Financial Agents of the U.S. Treasury.

CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began in August 2014 and will end in January 2015.

**Additional Information**


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

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**Healthcare Provider Taxonomy Codes (HPTC) Update, October 2014**


MLN Matters® Number: MM8866
Related Change Request (CR) #: CR 8866
Related CR Release Date: August 22, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3037CP
Implementation Date: January 5, 2015 – If capable, MACs can implement this effective October 1, 2014.

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 8866 implements the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Codes (HPTC) code set that is effective on October 1, 2014, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

**Background**

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

Both the current Accredited Standards Committee (ASC) X12 837 institutional and professional Technical Report Type 3 (TR3s) require the NUCC HPTC set be used to identify provider specialty information on a health care claim. The standards do not mandate the reporting of provider specialty information via a HPTC on every claim, nor for every provider to be identified by specialty.
The standard implementation guides state this information is:

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

**Note:** Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) website at [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the internet.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

### Additional Information

The official instruction, CR8866 issued to your MAC regarding this change is available [here](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3037CP.pdf) on the CMS website.

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

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**Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy -- Definition of “Spouse;” Same-Sex Marriages**


**MLN Matters® Number:** MM8875  
**Related Change Request (CR) #:** CR 8875  
**Related CR Release Date:** October 10, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R106MSP  
**Implementation Date:** January 1, 2015

### Provider Types Affected

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

### Provider Action Needed

**STOP — Impact to You**

Section 3 of the Defense of Marriage Act (DOMA) provided for purposes of federal law, the term “spouse” could not include individuals in a same-sex marriage. Because the MSP Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage.

The United States Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage.

**CAUTION — What You Need to Know**

Effective January 1, 2015, the rules below apply with respect to the term “spouse” under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration’s rules, that individual is a “spouse” for purposes of the MSP Working Aged provisions.
- If a marriage is valid in the jurisdiction in which it was
performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are “spouses” for purposes of the MSP Working Aged provisions.

- Where an employer, insurer, third party administrator, Group Health Plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the “spouse” in question. If such an individual is reported as a “spouse” through the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

GO — What You Need to Do

Make sure your billing staffs are aware of these changes.

Background

Based on Change Request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working aged provisions means “a person who is entitled to Medicare as a spouse based upon the Social Security Administration’s rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.”

The expanded rules for the definition of “spouse,” including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of “spouse” for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

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.

Manual Update to Clarify Claims Processing for Laboratory Services


MLN Matters® Number: MM8883
Related Change Request (CR) #: CR 8883
Related CR Release Date: September 19, 2014
Effective Date: December 22, 2014
Related CR Transmittal #: R3071CP
Implementation Date: December 22, 2014

Provider Types Affected

This MLN Matters® Article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare (DME) MACs for those services.

Provider Action Needed

Change Request (CR) 8883 updates the “Medicare Claims Processing Manual” to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

Key Points

The manual updates, which are attached to CR8883, are as follows:

- The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where
the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.

- Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.
- The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

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.

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)


MLN Matters® Number: SE1216 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 September 5, 2014, to add the “Where Can I Find My PTAN?” section on page 3. All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What You Need to Know

This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

Background

New Enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare Administrative Contractor (MAC), the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier’s NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National Provider Identifier (NPI)


- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website.

Provider Transaction Access Number (PTAN)

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc.
- The PTAN’s use should generally be limited to the provider’s contacts with their MAC.

Where can I find my PTAN?

You can find your PTAN by doing any one of the following:

1. View the letter sent by your MAC when your enrollment in Medicare was approved.
2. Log into Internet-based PECOS (https://nppes.cms.hhs.gov/NPPES/Welcome.do). Click on the “My Enrollments” button and then “View Enrollments”. Locate the applicable enrollment and click on the “View Medicare ID Report” link which will list all of the provider or supplier’s active PTANs in one report.
3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your MAC (http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf); include your legal name/legal business name, national provider identifier (NPI), telephone and fax numbers.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider’s enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- Note: The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider’s letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled “How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS),” provides guidelines and steps you can take to...

**Additional Information**


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**Fingerprint-based Background Check Begins August 6, 2014**


**MLN Matters® Number:** SE1427  
**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 providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

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**Provider Action Needed**

**STOP — Impact to You**

Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

**CAUTION — What You Need to Know**

The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the fingerprint requirements from their MAC. Initially, not all providers and suppliers in the “high” screening category will be a part of the first phase of the fingerprint-based background check requirement. See the Background section below for more details.

**GO — What You Need to Do**

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

**Background**

The Centers for Medicare & Medicaid Services (CMS) awarded the Fingerprint-based Background Check contract to Accurate Biometrics located in Chicago, Illinois on July 8, 2014. Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the “high” screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier’s correspondence address and the special payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request...
additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their website at [www.cmsfingerprinting.com](http://www.cmsfingerprinting.com) if you have any questions.

If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

**Additional Information**


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**Fees & Pricing**

**January 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**


**MLN Matters® Number:** MM8912  
**Related Change Request (CR) #:** CR 8912  
**Related CR Release Date:** September 19, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R3072CP  
**Implementation Date:** January 5, 2015

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

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 8912 instructs Medicare Administrative Contractors (MACs) to download and implement the January 2015 and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (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 January 5, 2015, with dates of service January 1, 2015, through March 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

**Background**

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

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 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>
<tr>
<td>January 2014 ASP and ASP NOC</td>
<td>January 1, 2014, through March 31, 2014</td>
</tr>
</tbody>
</table>

Additional Information


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

HCPCS Updates

Two New “K” Codes for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS)


MLN Matters® Number: MM8839 Revised
Related Change Request (CR) #: CR 8839
Related CR Release Date: August 26, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3052CP
Implementation Date: October 6, 2014

Note: This article was revised on August 28, 2014, to reflect the revised CR8839 issued on August 26, 2014. 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 suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8839 announces that, effective October 1, 2014, two new “K” codes (K0901 and K0902) will be established for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS). The addition of these codes will allow the DME MACs to correctly adjudicate claims. Make sure your billing staffs are aware of these changes.

Background

• The orthotics currently paid under Section 1834(h) (Payment for Prosthetic Devices and Orthotics and Prosthetics) of the Social Security Act (the Act), and that are described in its Section 1861(s)(9) (Part E—Miscellaneous Provisions, Definitions of Services, Institutions, etc.) are leg, arm, back, and neck braces. (You can find these sections of the Act at
Definitions


● The “Medicare Benefit Policy Manual,” Chapter 15 (Covered Medical and Other Health Services), Section 130 (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) provides the longstanding Medicare definition of “braces” as “rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.” (You can find this manual section at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website).

● Further, Section 1847(a)(2) of the Act defines OTS orthotics as those for which payment would otherwise be made under Section 1834(h), above; which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. You can find this section of the act at http://www.ssa.gov/OP_Home/ssact/title18/1847.htm.

● Lastly, the Center for Medicare & Medicaid Services (CMS) regulations at 42 CFR 414.402, which you can find at http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/html/CFR-2007-title42-vol3-sec414-402.htm, define the term “minimal self-adjustment” as “an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform; and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.”

New OTS Orthotics Healthcare Common Procedure Coding System (HCPCS) Codes

In February 2012, CMS issued guidance that initially identified specific HCPCS codes that were considered OTS orthoses. The list of HCPCS codes that were finalized as part of this review as OTS orthotics, effective January 1, 2014, are available for download at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

CR8839announces that in order to identify prefabricated single and double upright knee orthoses that are furnished in a variety of standard sizes and do not require the skills of an expert to measure and fit to the individual; the following OTS codes will be added to the HCPCS code set, effective October 1, 2014:

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;

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.

2015 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update


MLN Matters® Number: MM8943
Related Change Request (CR) #: CR 8943
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3088CP
Implementation Date: January 5, 2015

Provider Types Affe

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health &
Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

**Provider Action Needed**

**STOP — Impact to You**

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 8943 could impact your payments.

**CAUTION — What You Need to Know**

CR 8943 provides the 2015 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems.

By the first week in December 2014, the new code files for B MAC processing, and the new Excel and PDF files for A MAC processing will be available at [http://www.cms.gov/SNFConsolidatedBilling](http://www.cms.gov/SNFConsolidatedBilling) on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2015.

**GO — What You Need to Do**

It is **important and necessary** to read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

**Background**

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the “Medicare Claims Processing Manual,” Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf) on the CMS 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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

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**Competitive Bidding**

**Competitively Bid Wheelchair Accessories:**

**Guidance on claims billing and processing effective January 5, 2015**

This article provides important information on changes which will be implemented by all DME MACs on January 5, 2015!

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8864 ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8864.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8864.pdf)) which provided guidance regarding CMS claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a Competitive Bidding Area (CBA). The CR will implement corrections within VIPS Medicare System (VMS) which will allow for correct processing and payment of these claims. The changes outlined in the CR will be implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) on January 5, 2015, and will be effective for claims processed on or after January 5, 2015.

Due to the complexity of the issues, suppliers with claims which are identified as either having been incorrectly paid to contract suppliers or denied to non-contract suppliers will need to submit their appeal requests to the DME MAC’s Reopening department. Please include all affected PTANS and indicate whether the claims were denied or paid incorrectly.
Contract suppliers must submit their requests after January 5, 2015, to ensure the claim will be paid at the appropriate payment rate.

Non-contract suppliers may submit their claims prior to January 5th for proper adjudication. If multiple claims are involved, you may submit a single reopening request for those specific claims.


If you have any questions, please contact the Jurisdiction C Provider Contact Center at 1-866-270-4909 (http://www.cgsmedicare.com/jc/cs/index.html).

Related Information:

- Reopenings Request Form (http://www.cgsmedicare.com/jc/forms/pdf/jc_reopenings_form.pdf)
- Reopenings Request Form Completion Guide (http://www.cgsmedicare.com/jc/forms/pdf/dme_reopening_guide.pdf)
- Reopenings Checklist (http://www.cgsmedicare.com/jc/forms/pdf/jc_reopenings_checklist.pdf)

Related Education:

- Welcome to Medicare Segment 9: Reopenings (http://www.cgsmedicare.com/jc/education/online_education.html)

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


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

Note: This article was revised on October 16, 2014, to reference the correct HCPCS codes and to add a link to the Quarterly Update pages of the competitive bidding website in the “What You Need to Know” section. All other information remains the same.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8676 to provide the DMEPOS Competitive Bidding Program (CBP) October 2014 quarterly update. CR 8676 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are also posted to http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home on the Internet. At that site, click on the quarterly updates link in the left of the page.

ZIP Codes (Round 2 Only)

The following ZIP codes have been added to the Round 2 ZIP code files listed below to conform with U.S. Postal Service ZIP code changes within the identified competitive bidding areas:

- 97003 Portland-Vancouver-Beaverton, OR-WA
- 97078 Portland-Vancouver-Beaverton, OR-WA
- 20252 Washington-Arlington-Alexandria, DC-VA-MD-WV
The ZIP code files can be used to identify when a specific item furnished to a beneficiary is subject to the Competitive Bidding Program.

**HCPCS Codes (Round 1 Recompete Only)**

Effective January 1, 2014, the Round 1 Recompete Single Payment Amount file has been updated to replace HCPCS code, E0731NU, with HCPCS code, E0731NUKG. This change allows Medicare to accurately process and pay HCPCS code E0731 (Form Fitting Conductive Garment for Delivery of TENS or NMES (with Conductive Fibers Separated from the Patient’s Skin by Layers of Fabric)) according to competitive bidding payment rules when used in conjunction with a competitive bidding base unit, such as a TENS device.

**Background**

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

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

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

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

**Additional Information**


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

**Competitive Bidding Program (CBP): Correction to VIPS Medicare System (VMS) Processing of Wheelchair Accessory Claims for Round 2**


MLN Matters® Number: MM8864
Related Change Request (CR) #: CR 8864
Related CR Release Date: August 15, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1420OTN
Implementation Date: January 5, 2015 - For claims processed on and after January 5, 2015
Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) for standard power wheelchair and manual wheelchair accessories furnished to Medicare beneficiaries who reside in competitively bid areas (CBAs) as well as some items for beneficiaries residing outside a CBA.

Provider Action Needed

Change Request (CR) 8864 is a clarification of CR8181 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a CBA.

For the purpose of CR8864, “Round 1” refers to the original Round 1 and not the Round 1 Rebid. “Round 2” refers to Round 2 and any subsequent Rounds (such as the Round 2 Recompete).

CR8864 implements corrections within Medicare systems to address the following:

1. Payments for wheelchair accessories furnished for use with Complex Group 2 and Group 3 Power Wheelchairs (identified by HCPCS K0835 – K0843 and K0848 – K0864) by contract suppliers for beneficiaries residing in a CBA;

2. Payments for competitively bid wheelchair accessories furnished for use with wheelchair base units that were not bid in Round 1 or Round 2 by contract and non-contract suppliers for beneficiaries residing in a CBA;

3. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with any wheelchair base unit to beneficiaries residing outside a CBA; and

4. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with wheelchair base units that were not competitively bid in Round 2 to beneficiaries residing in a CBA.

Additionally, effective for claims processed on or after January 1, 2015, MACs will allow payment for wheelchair accessories that are furnished for use with a non-competitively bid base unit, even if the accessories are received after the end date of the certificate of medical necessity (CMN). These accessories can be supplied by any Medicare-enrolled supplier provided they append modifier “KY”.

Make sure your billing staffs are aware of these changes.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new Competitive Bidding Program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas.

All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Policy Scenarios

Effective for claims processed on or after January 1, 2015, MACs will apply the policy indicated to payments made for wheelchair accessories during Round 2 in each of the following scenarios:

Scenario 1

In this scenario, MACs will pay the fee schedule amount (-9.5 percent) for the wheelchair accessory used with the non-bid wheelchair base rather than paying the single payment amount (SPA).

- Wheelchair accessory is competitively bid in Round 1 and Round 2;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2);
- Billed with modifier “KY”;
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.
Scenario 2

In this scenario, MACs will pay the fee schedule amount (5%) for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 1 and Round 2;
- Billed for use with a non-competitively bid base unit that was not bid in Round 1 or Round 2 (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239);
- Billed with modifiers “KE” and “KY”;
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

Scenario 3

In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with any wheelchair base unit (whether competitively bid or not);
- Billed without modifier “KE” or “KY”;
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides outside a CBA.

Scenario 4

In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2) OR for use with a non-competitively bid base unit that was not bid in Round 1 or Round 2 (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239);
- Billed with modifier “KY”;
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

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.

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


MLN Matters® Number: MM8907
Related Change Request (CR) #: CR 8907
Related CR Release Date: September 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3068CP
Implementation Date: January 5, 2015

Provider Types Affected

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

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8907 to provide the DMEPOS Competitive Bidding Program (CBP) January 2015 quarterly update. Change Request (CR) 8907 provides specific instructions for the DME MACs in implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards.

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

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

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

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

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

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.
News Flash Items
From MLN Matters Articles:

(REVISION) Product from the Medicare Learning Network® (MLN)


(REVISION) Product from the Medicare Learning Network® (MLN)

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, visit:

- HealthMap Vaccine Finder (http://vaccine.healthmap.org/) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.
- The CDC website for Free Resources (http://www.cdc.gov/flu/freeresources/), including prescription-style tear-pads (http://www.cdc.gov/pubs/nicird.aspx#Flu) that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

(REVISION) Product from the Medicare Learning Network® (MLN)

“Provider Compliance Tips for Computed Tomography (CT Scans)” - Fact sheet (ICN 907793) EPUB, QR
NEW products from the Medicare Learning Network® (MLN)


REVISED products from the Medicare Learning Network® (MLN)


News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862(a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article SE1126 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf), “Further Details on the Revalidation of Provider Enrollment Information.”

REVISED product from the Medicare Learning Network® (MLN)


NEW product from the Medicare Learning Network® (MLN)

- “Medicaid Compliance and Your Dental Practice” Fact Sheet, ICN 908668, Downloadable only. (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicaid_Compliance_ICN908668.pdf)

NEW product from the Medicare Learning Network® (MLN)


REVISED products from the Medicare Learning Network® (MLN)


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REVISED products from the MLN

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<td><strong>CEDI (toll-free):</strong> 1.866.311.9184</td>
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