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DME POE Coming to You in 2017!

- CGS Publication

The Jurisdiction C DME Provider Outreach and Education team is excited to announce locations of our live events in 2017! Here are the geographic areas where we plan to conduct live education (with possible dates in parentheses):

- Charlotte, North Carolina (May 10, 2017)
- Nashville, Tennessee (June 21, 2017 – Huge workshop with Jurisdiction B suppliers!)
- San Juan, Puerto Rico (June 2017)
- San Antonio, Texas (July 12, 2017)
- Atlanta, Georgia (August 2017)
- Tampa, Florida (September 2017)
- Dallas, Texas (October 2017)

All of our live events give you the opportunity to meet CGS POE representatives for a day of focused Medicare education.

Our events in the San Juan, Atlanta, Tampa, and Dallas areas will be a great way to get your questions answered as the Provider Outreach representatives conduct focused education on issues and trends that affect all DME suppliers. There are numerous opportunities for discussion during the workshop day, so be sure to bring your questions! Suppliers always leave with new knowledge or a new approach to an existing problem back at the office.

The events in Charlotte, Nashville, and San Antonio will be Mega workshops and there will be multiple sessions for you to attend throughout the day, so check the entire schedule during registration and sign up for the classes that will best fit you and your particular business model. For example, look for a “track” for the newer supplier or employee where foundational concepts and requirements will be reviewed. You can also expect sessions geared toward suppliers involved in the respiratory industry as well as those suppliers who provide orthotics and prosthetics to beneficiaries.

Watch the DME Jurisdiction C ListServ for announcements on registration and the exact location (city and venue) where the workshops will be held. Go to [http://www.cgsmedicare.com/jc/education/workshops.html](http://www.cgsmedicare.com/jc/education/workshops.html) for more information.

We look forward to seeing you at one of our events this year!
See What CGS Education Can Do For You!

- CGS Publication

The Education section of the CGS website offers a wealth of valuable self-service resources to help you achieve compliance with Medicare policy. The New Supplier Welcome Center helps new Medicare suppliers with everything from enrollment information to important claim submission education and resources. The Education page also provides a Calendar of Events detailing upcoming webinars, workshops, Ask-the-Contractor teleconferences (ACT) and association meetings. The Online and Video Education pages contain a broad range of computer-based modules in both general and policy-specific subjects as well as instructor-led video tutorials which are perfect for helping current staff brush up on their knowledge. Many suppliers also use our online education services to supplement their in-house training for new employees. We even provide most of our education in both English and Spanish! Our scenario-based education is designed to help suppliers improve their billing proficiency and bottom-line by avoiding denials, reopenings and appeals. Visit the CGS Education pages for Jurisdiction B (http://www.cgsmedicare.com/jb/education/index.html) or Jurisdiction C (http://www.cgsmedicare.com/jc/education/index.html) today to see what CGS education can do for you!

Help Improve CGS Web Site—It’s Easy & Productive...

Yesterday, I needed some information from the CGS web site. As I have urged you to do, I agreed to take the survey after I finished my visit. It only took about two or three minutes, and that included using the comment boxes for making suggestions. As requested, I provided an email address for follow up.

Already this morning, that follow up has occurred! It included an opportunity for me to elaborate on my suggestion beyond the Twitter-like confines of a dialog box, and a thorough explanation of why it was done the way it was. I now have a clear understanding of CGS’ limitations, and I know what to expect on any future visit for a similar purpose.

The follow up could just as easily have been a solution to getting information I needed to get a claim or claims paid, or information on what was missing that I could send to win an audit.

In short, completing that survey can be very productive in the short term, as well as allowing for improvements in the future that meet your needs exactly. Don’t be concerned about whether or not what you want can be done—ask anyway! If your request can’t be made available, they will tell you why, but sometimes all it takes is a number of similar requests to generate a significant improvement.

Bottom line: take the survey at least once a month until further notice. Use the comment boxes, and include your email address. It will help our favorite MAC and that means it will also help you.

Reprinted by permission: Mike Hamilton, Executive Director, ADMEA, shared the following with members of the Alabama Durable Medical Equipment Association following a recent, positive interaction with CGS website staff.
Learning Opportunities through Provider Education

Dear Physician Letters
Calendar of Events
LiveLine PLUS
Online Education
Video Education
Workshops & Seminars

Webinars
ACT
POE Advisory Group
Community Coach
Supplier Training & MORE

www.cgsmedicare.com/jc/education/index.html
www.cgsmedicare.com/jb/education/index.html
Use the Correct Lockbox for Refunds

- CGS Publication

Each CGS DME MAC Jurisdiction has a separate lockbox that refund checks should be sent to. Sending your refund to the incorrect lockbox or combining refunds for separate jurisdictions into one check could cause a delay in the processing of your check. Thank you for your cooperation that helps us process your refund checks more timely and efficiently by using the correct lockbox for the contract that is being refunded.

DME JB CGS Administrators, LLC
PO Box 953479
St. Louis, MO 63195

DME JC CGS Administrators, LLC
PO Box 955152
St. Louis, MO 63195

If you need additional information on refund checks please see the CGS Website: http://www.cgsmedicare.com.

COVERAGE & BILLING

Diapers and Underpads - Correct Coding

- DME MAC Joint Publication


Recent reports have identified that suppliers are billing Healthcare Common Procedure Coding System (HCPCS) codes A9999 (MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED) or E1399 (DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS) for diapers and underpads. These miscellaneous codes are not the correct codes to use for billing these items. The correct codes to bill for these items are:

- A4520 INCONTINENCE GARMENT, ANY TYPE, (E.G., BRIEF, DIAPER), EACH
- A4554 DISPOSABLE UNDERPADS, ALL SIZES
- A4553 NON-DISPOSABLE UNDERPADS, ALL SIZES (effective for claims with date of service on or after January 1, 2017)

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor 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 at https://www.dmepdac.com/contact/index.html.
LIM Innovation Below Knee Socket - Correct Coding

- DME MAC Joint Publication


Originally Published May 21, 2015; Updated March 10, 2016; Updated December 08, 2016

Infinite Socket™ (LIM innovations) is an open-frame below-knee socket design that has recently become available. This product uses struts that extend from a base to an adjustable brim enclosing an inner shell to form the structure of the socket. It is custom-fabricated from a model of the patient’s residual limb.

The existing Healthcare Common Procedure Coding System (HCPCS) L-codes used for below-knee lower limb prosthesis sockets describe items which enclose the residual limb to provide the stability, proprioception, and suspension necessary for the effective use of the artificial limb. Although the LIM innovations Infinite Socket™ is different in design from traditional sockets described by the existing L-codes, it has been determined that the socket design has critical design elements to meet the coding requirements for the following HCPCS codes. The correct combinations of HCPCS codes to bill Medicare for this item are described in the table below:

1. Base code for complete prosthesis (choose one)
   - L5301 BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT, ENDOSKELETAL SYSTEM
   - L5540 PREPARATORY, BELOW KNEE ‘PTB’ TYPE SOCKET, NON-ALIGNABLE SYSTEM, PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL

2. Base code for socket replacement
   - L5700 REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL

3. Addition codes to always bill with one of the above base codes
   - L5629 ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLIC SOCKET
   - L5637 ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL CONTACT
   - L5940 ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)

4. Addition codes that are not to be billed
   - L5620 ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE
   - L5646 ADDITION TO LOWER EXTREMITY, BELOW KNEE, AIR, FLUID, GEL OR EQUAL, CUSHION SOCKET L5668 ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED DISTAL CUSHION

The add-on codes L5629, L5637, L5940, and the HCPCS codes describing the choice of suspension must be included on the same claim for the complete prosthesis or socket replacement, i.e., the claim that includes one of the above base codes.

Do not use L5301 or L5540 for billing a replacement socket for an existing prosthesis.

HCPCS code L5999 (LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED) must not be used to bill for any features or functions included in the socket. The combinations of base and addition codes listed above include all the features and functions of the design. Use of L5999 is incorrect coding (unbundling).
HCPCS codes used to describe the type of suspension incorporated into the socket must be added to the claim. Use of more than one type of suspension per limb is considered incorrect billing (same/similar item).

HCPCS codes describing features that may not be necessary on all sockets or prostheses may only be used when the feature is provided for the individual beneficiary. Some examples of features that are not automatically included in every socket or for all beneficiaries are (not all-inclusive):

- L5645 ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME
- L5910 ADDITION, ENDO Skeletal SYSTEM, BELOW KNEE, ALIGNABLE SYSTEM

Do not bill L5910 when providing a replacement socket as this addition was previously reimbursed with the provision of the complete prosthesis. Claims for L5910 in conjunction with any replacement socket are considered incorrect billing.

The prosthetic record must include specific, detailed information justifying the need for each additional feature.


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

**Oral Appliances Not Used For the Treatment of Obstructive Sleep Apnea - Correct Coding**

- **DME MAC Joint Publication**


Oral appliances are used for the treatment of many conditions related to the mouth, teeth and jaw. Most of these items used to treat these conditions do not fall within the jurisdiction of the Durable Medical Equipment Medicare Administrative Contractors (DME MAC).

Only oral appliances that meet the requirements to be classified as DME are eligible to use HCPCS codes E0485 and E0486. The Oral Appliances Used for the Treatment of Obstructive Sleep Apnea Local Coverage Determination (LCD) excludes devices coded as E0485 from reimbursement. Only products reviewed by the Pricing, Data Analysis and Coding (PDAC) contractor and included on the Durable Medical Equipment Coding System’s (DMECS) Product Classification List may be coded as E0486.

All other oral appliances are classified by HCPCS “D” or “S” codes. HCPCS “D” codes are used for dental items and procedures. HCPCS “S” codes are not used by Medicare. HCPCS “D” and “S” codes do not fall within the jurisdiction of the Medicare DME MACs or PDAC. PDAC does not provide coding advice for these HCPCS codes. Questions about “D” codes should be directed to the A/B MAC contractors. Questions about HCPCS “S” codes should be directed to the non-Medicare payer to whom a claim will be submitted.

Questions concerning HCPCS code classifications should be directed to the Pricing, Data Analysis and Coding (PDAC) contractor - Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or email the PDAC by completing the DME PDAC Contact Form located on the PDAC website https://www.dmepdac.com/dmecs/.

WHILL Powered Personal Mobility Devices - Correct Coding - Revised

- DME MAC Joint Publication


Originally Published May 14, 2015; Revised July 21, 2016; Revised December 15, 2016
This is a revision to the article, “Correct Coding - WHILL Powered Personal Mobility Devices”, published in July 2016. This article updates the HCPCS Code assignment for WHILL Model M.

Note: WHILL, Inc., (San Carlos, CA), is the manufacturer of WHILL powered personal mobility devices. They currently have two power wheelchair (PWC) products, Model A and Model M.

WHILL Model A
The FDA has not approved the WHILL Model A. FDA approval is required by Medicare; therefore, it not considered a medical device. Consequently, this item is non-covered (no Medicare benefit). For Medicare billing purposes, claims for the WHILL Model A must be submitted using the following HCPCS code:

A9270 - NONCOVERED ITEM OR SERVICE

This code is considered as all-inclusive for this product. None of the existing HCPCS codes for wheelchair bases, options, accessories, seating, etc. are appropriate for use with this product. Claims for this item using existing wheelchair-related codes will be denied as incorrect coding.

WHILL Model M
The WHILL Model M received a 510(k) FDA clearance for marketing as a Class II Powered Wheelchair on February 12, 2016. A HCPCS code request for this product has been submitted to the Pricing, Data Analysis and Coding (PDAC) Contractor and a HCPCS code assignment has been made. The WHILL Model M is a four-wheel drive PWC. Four-wheel drive is a capability that is not needed for use in the home. PWCs with functionality that is not needed in the home are classified into PWC Group 4; however, this product failed to meet several other Group 4 performance-testing requirements. Therefore, for Medicare billing purposes, claims for this device must be submitted using the following HCPCS code:

K0898 - POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED

This code is considered as all-inclusive for this product. None of the existing HCPCS codes for wheelchair bases, options, accessories, seating, etc. are appropriate for use with this product.
Claims for this item using existing wheelchair-related codes other than HCPCS code K0898 will be denied as incorrect coding.

Items billed with any HCPCS code with a narrative description that indicates miscellaneous, not otherwise classified (NOC), unlisted, or non-specified, must also include the following information in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or on Item 19 of the paper claim form:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

Miscellaneous HCPCS codes billed without this information will be rejected and will need to be resubmitted with the missing information included.

**General Information**

DMEPOS Suppliers are reminded that:

- As noted in the DME MAC Power Mobility Devices Local Coverage Determination and related Policy Article, products with capabilities that exceed what is required in the home setting are considered not reasonable and necessary.
- There is no Medicare reimbursement available for repairs or replacement of non-covered items.

Refer to the Power Mobility Devices, Wheelchair Options and Accessories, and Wheelchair Seating LCDs and related Policy Articles for additional information on coverage, coding and documentation requirements.

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

**References:**

Manual Wheelchairs Constructed of Titanium -
Correct Coding

- DME MAC Joint Publication


A recent review of K0108 (WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED) identified increased billing for items that are characterized by titanium construction or heavy-duty packages constructed with titanium. The HCPCS codes for manual wheelchairs (K0001-K0009*) were created in 1993, effective for dates of service on or after January 1, 1994. The HCPCS codes for manual wheelchair bases are:

- K0001 STANDARD WHEELCHAIR
- K0002 STANDARD HEMI (LOW SEAT) WHEELCHAIR
- K0003 LIGHTWEIGHT WHEELCHAIR
- K0004 HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR
- K0005 UTRALIGHTWEIGHT WHEELCHAIR
- K0006 HEAVY DUTY WHEELCHAIR
- K0007 EXTRA HEAVY DUTY WHEELCHAIR
- K0008 CUSTOM MANUAL WHEELCHAIR/BASE
- K0009 OTHER MANUAL WHEELCHAIR/BASE

The Medicare fee schedule amount for these codes was established with the original code and included the cost of titanium-containing manual wheelchairs. Suppliers billing for manual wheelchair bases must not include HCPCS code K0108 in addition to the base wheelchair code when a wheelchair is constructed of titanium or for a “heavy duty package” reflecting titanium construction materials. Claim HCPCS code K0108 reflecting titanium construction or “heavy duty package” comprised of titanium components, are considered as incorrect coding - unbundling.

The Manual Wheelchair Local Coverage Determination related Policy Article Coding Guidelines detail the specifications that are used to assign codes to manual wheelchair bases. Manual wheelchairs constructed of titanium are assigned coding based upon these coding guideline specifications.


For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor 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 at https://www.dmepdac.com/.

* K0008 had an effective date of October 1, 1994. This code was discontinued July 1, 2001 and reinstated July 1, 2013.
Negative Pressure Wound Therapy (NPWT) - Correct Coding

- DME MAC Joint Publication

Recently it has come to the attention of the DME MACs that suppliers are billing separately for wound dressings and related dressing change items used with negative pressure wound therapy pumps (HCPCS code E2402). As noted in the Negative Pressure Wound Therapy Local Coverage Determination (LCD) and related Policy Article (PA) (effective 10/01/2015*), the allowance for wound dressings HCPCS code A6550 includes all items necessary for the effective utilization of the wound pump. The NPWT LCD related PA coding guideline states:

Code A6550 describes an allowance for a dressing set which is used in conjunction with a stationary or portable NPWT pump (E2402). **A single code A6550 is used for each single, complete dressing change, and contains all necessary components, including but not limited to any separate, non-adherent porous dressing(s), drainage tubing, and an occlusive dressing(s) which creates a seal around the wound site for maintaining sub-atmospheric pressure at the wound.** [Emphasis Added]

* This long-standing bundling provision has been effective since 10/01/2011.

Suppliers must not bill separately for any components of code A6550 including, but not limited to:

- any dressing type (impregnated gauze, hydrogels, specialty absorptive dressings or other adherent or non-adherent dressings, etc.)
- antiseptics
- anesthetics
- gloves
- tubing
- adhesives
- any other item necessary to perform a complete dressing change associated with a negative pressure wound pump.

Claims for dressing-related items used in conjunction with code E2402 and billed separately will be denied as unbundling.


For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor 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 at https://www.dmepdac.com/.
Recently there have been questions about the billing of hospital beds at the same time as a mattress-type pressure reducing support surface (PRSS). The DME MACs remind suppliers that billing a hospital bed with mattress in conjunction with a mattress-type support surface (i.e., not a support surface mattress overlay) is considered to be a claim for duplicate items (same/similar). Suppliers must not bill HCPCS codes for two types of mattresses concurrently. Refer to the list below for the relevant HCPCS codes for mattress-type PRSS and hospital beds with included mattresses. There are several possible billing scenarios:

- **Beneficiary-owned hospital bed with mattress**: Providing a mattress-type PRSS to replace an existing mattress is allowed if there is a change in the beneficiary’s medical condition that justifies coverage of the PRSS. Since the beneficiary owns the regular mattress, it is their decision regarding the disposition of the regular mattress. The supplier may bill for the appropriate HCPCS code for the PRSS provided.

- **Hospital bed with mattress currently in a capped rental**: Providing a mattress-type PRSS to replace an existing mattress is allowed if there is a change in the beneficiary’s medical condition that justifies coverage of the PRSS. In this scenario, the regular mattress must be returned to the supplier and the supplier must stop billing the HCPCS code for the combination bed with mattress. Only then may the supplier change the HCPCS code being billed to the corresponding HCPCS code for the hospital bed frame without a mattress. The hospital bed frame without mattress rental payments will resume in the capped rental cycle in the month following discontinuation of the hospital bed with mattress. A new capped rental does not begin with the change in hospital bed HCPCS code. The supplier may bill for the appropriate HCPCS code for the PRSS provided.

- **New, initial rental of both a hospital bed and PRSS**: Combination hospital bed and mattress codes and a PRSS must not be billed at initial issue. Suppliers must bill the appropriate HCPCS code for the hospital bed frame without mattress plus the HCPCS code for the mattress-type PRSS.

The following list of HCPCS codes and descriptors detail the Group 1 and Group 2 mattress-type PRSS and the hospital beds that include mattresses:

- **Group 1 Support Surface Mattress Codes**
  - E0184 DRY PRESSURE MATTRESS
  - E0186 AIR PRESSURE MATTRESS
  - E0187 WATER PRESSURE MATTRESS
  - E0196 GEL PRESSURE MATTRESS

- **Group 2 Support Surface Mattress Codes**
  - E0193 POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
  - E0277 POWERED PRESSURE-REDUCING AIR MATTRESS
  - E0373 NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS

- **Fixed Height Beds with Mattresses Codes**
  - E0250 HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
• **E0290** HOSPITAL BED, FIXED HEIGHT, WITHOUT SIDE RAILS, WITH MATTRESS
• **E0328** HOSPITAL BED, PEDIATRIC, MANUAL, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS

• Variable Height Beds with Mattresses Codes
  • **E0255** HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
  • **E0292** HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITH MATTRESS

• Semi-Electric Beds with Mattresses Codes
  • **E0260** HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
  • **E0294** HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITH MATTRESS
  • **E0329** HOSPITAL BED, PEDIATRIC, ELECTRIC OR SEMI-ELECTRIC, 360 DEGREE SIDE ENCLOSURES, TOP OF HEADBOARD, FOOTBOARD AND SIDE RAILS UP TO 24 INCHES ABOVE THE SPRING, INCLUDES MATTRESS

• Total Electric Beds with Mattresses Codes
  • **E0265** HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITH ANY TYPE SIDE RAILS, WITH MATTRESS
  • **E0296** HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS

Refer to the Hospital Bed and relevant Pressure Reducing Support Surface Local Coverage Determination and related Policy Article for additional information about coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor 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 at [https://www.dmepdac.com/](https://www.dmepdac.com/).

**References:**

Keeping You Connected
Reminder – Oxygen Qualification Tests and Documentation

-DME MAC Joint Publication

Link to current version on the CGS website: http://www.cgsmedicare.com/articles/cope2380.html

With recent advances in electronic health records and billing software, healthcare providers and durable medical equipment (DME) suppliers often have interconnected systems for the transmission of medical records and other documentation such as orders. Suppliers are reminded that the Centers for Medicare and Medicaid Services National Coverage Determination for Home Oxygen Therapy (Internet-Only Manual 100-03, Chapter 1, Section 4, 240.1) and the DME MAC Local Coverage Determination and related Policy Article on Oxygen Equipment both prohibit supplier involvement in the qualifying test process for home oxygen therapy. As noted in the DME MAC Oxygen Equipment LCD:

The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests. [Emphasis Added]

In addition to the rules noted above, suppliers are also reminded that the ordering of any oxygen qualification test (i.e., arterial blood gas or pulse oximetry) may only be done by the treating practitioner, with the results sent directly to the treating practitioner. The common practice where a DMEPOS supplier arranges or otherwise facilitates testing and subsequently has the practitioner “order” the already conducted test does not result in a qualified test for the purpose of Medicare oxygen reimbursement. Refer to the DME MAC Oxygen Equipment LCD (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33797) and related PA (https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=52514) for additional coverage, coding and documentation requirements.

CERT Errors – Proof of Delivery

-CGS Publication

The Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) have noted an increase in Comprehensive Error Rate Testing (CERT) denials for Proof of Delivery (POD) issues. There are two methods for POD that may be utilized for all DME items:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service

Note: Some policies also have Method 3, delivery of items to a nursing facility on behalf of the beneficiary. Currently the DME MACs are not seeing CERT denials related to this method.

Per the Program Integrity Manual (PIM) Chapter 4.26 and 5.8, Method 1—Direct Delivery to the
Beneficiary by the Supplier. Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary’s name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

Method 1 is direct delivery to the beneficiary or authorized representative. Listed below is a common CERT denial comment for this POD method:

**TECHNICAL BILLING ERROR: Submitted documentation shows the beneficiary signed for and took receipt of the Lancets on 06/30/2016 – not the billed date of service 06/27/2016.**

**RECEIVED: 1) Proof of delivery signed and dated by a designee on 06/30/2016.**

When suppliers utilize Method 1 per the policy, “The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee.”

Common scenarios for billing an incorrect date of service (DOS) include: the date the order was filled, the date the beneficiary orders the items, the date the beneficiary says they will be in to pick up the item.

To avoid this type of error, suppliers must always make sure the DOS on the claim matches the date the beneficiary or authorized designee picked up the DME item(s).

Per the PIM Chapter 4.26 and 5.8 Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary, If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier’s own detailed shipping invoice and the delivery service’s tracking information. The supplier’s record must be linked to the delivery service record by some clear method like the delivery service’s package identification number or supplier’s invoice number for the package sent to the beneficiary. The POD document must include:

- Beneficiary’s name
- Delivery address
- Delivery service’s package identification number, supplier invoice number, or alternative method that links the supplier’s delivery documents with the delivery service’s records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

Method two is delivery via shipping or delivery service. Listed below is a common CERT denial comment for this method:

**MISSING: 1) Proof of delivery that is inclusive of supplier’s record/tracking information that is detailed to support the items shipped and linked to delivery services’ records.**
RECEIVED: Proof of delivery without beneficiary address and tracking without delivery address.

In cases when a shipping or delivery service is use, suppliers often forget to send in the complete set of documents to support the tracking information. The following documents are needed to complete a proper POD:

- Tracking information from the shipping or delivery service
- Supplier’s invoice that lists, in detail, what DME items were sent to the beneficiary
- Address of beneficiary
- Ship date (Which will serve as the DOS)

Reviewers must be able to identify the item(s) shipped and see that the item(s) were delivered.

For additional information CGS CERT resources please visit the JB and JC CERT pages at:


Reopenings for Nebulizer Claims due to Diagnosis Codes

- CGS Publication


CGS saw an increase in the 2016 4th quarter for nebulizer claims being adjudicated through the reopenings process. Suppliers submitted noncovered or incorrect ICD-10 diagnosis codes, and through the reopenings process, requested covered diagnosis codes to be added to the claim. Suppliers could avoid the reopenings process and payment delays by reviewing the claim for the appropriate covered diagnosis code prior to submission to the Jurisdiction B and C Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

The nebulizer policy is a diagnosis-driven policy; therefore, when a diagnosis does not support the medical necessity, the claim line will be denied with American National Standard Institute (ANSI) CO-50. CO-50 denials relieve beneficiaries of financial liability and suppliers cannot resubmit the claim with the appropriate covered diagnosis code because of the medical necessity denial. As such, suppliers are utilizing the reopenings process to add the appropriate covered diagnosis code which causes a delay in payment. Suppliers are reminded that CGS must complete reopening requests within 60 calendar days of receipt of the request.

Suppliers are encouraged to work with their software vendors to have edits in place for nebulizer claims due to the specified diagnosis codes for each item listed in the nebulizer medical policy. By submitting claims initially with the appropriate covered diagnosis codes, suppliers are able to avoid the delay in payment associated with filing reopenings.

For information regarding the coverage, medical necessity, documentation requirements, and coding guidelines for nebulizers and accessories, please read the nebulizers LCD and related policy article. CGS also provides additional policy education in the Online Education Welcome Center at www.CGSMedicare.com.
DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Revised

- DME MAC Joint Publication


Originally published in January 2015; republished in June 2015
Revision: January 2017

NOTE: This article was originally published in January 2015, republished in June 2015. The June 2015 revision reflected that external infusion pumps do not require a recertification DIF when the length of need expires and the ordering physician extends the length of need. A revised DIF is the proper form for the supplier to complete. This January 2017 revision corrects a clerical error that at the end of the article inadvertently left the instructions for suppliers to obtain a recertification DIF when length of need expires and the ordering physician extends the length of need.

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

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

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

Initial DIF:

A new Initial DIF is required when:

1. An enteral formula billed with a different code, which has not been previously certified, is ordered; or,
2. For either enteral formulas or administration via pump (B9000 or B9002), there has been a break in billing of more than 60 days (plus the remaining days in the rental month) and there has been a change in the underlying medical condition that justifies coverage for the item(s).
3. A beneficiary receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump* (B9000 or B9002).
   * Change in method of administration from gravity or syringe to a pump (B9000 or B9002) requires a new initial DIF for the pump and a revised DIF for the enteral nutrient (See chart below).

Revised DIF:

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

| External Infusion Pumps | • Changes in the existing drug HCPCS code  
|                        | • Substitution of drug HCPCS code for existing drug HCPCS code  
|                        | • Addition of drug HCPCS code  
|                        | • Change in the route of administration  
|                        | • Change in method of administration  
|                        | • Extend expired length of need  
| Enteral and Parenteral Nutrition | • Change in HCPCS code for the current nutrient provided  
|                                 | • Change (increase or decrease) in the calories prescribed  
|                                 | • Change in the method of administration from gravity to syringe or syringe to gravity (See above for gravity or syringe to pump)  
|                                 | • Change in the number of days per week of administration  
|                                 | • Change in route of administration from tube feedings to oral feedings (if billing for denial)  


For additional information, refer to the Supplier Manual located at [http://www.cgsmedicare.com/jc/pubs/supman/index.html](http://www.cgsmedicare.com/jc/pubs/supman/index.html), and the applicable Local Coverage Determination, and related Policy Article.
December 08, 2016

RE: DURABLE MEDICAL EQUIPMENT – AN EASY OPTION FOR DOCUMENTING CONTINUED USE

Dear Physician,

Medicare doesn’t pay for equipment that you’ve ordered for your Medicare patient if it isn’t being used. Unfortunately, medical records from office visits often fail to mention that a patient continues to use home medical equipment such as a hospital bed, CPAP equipment or nebulizer. This is understandable since in some cases, the patient may have been using the equipment for several months or even years. However, it is necessary to document that the equipment continues to be used in order to obtain supplies for that equipment. One easy way to accomplish this is to include medical equipment that you’ve ordered for your patient on their medication list.

Many “model charts” from various clinical organizations recommend maintenance of a medication list that indicates the medication(s), strength, dosing schedule, and what the patient is actually taking. At each visit, the date of the visit is recorded and notations are made regarding the patient’s adherence with each medication. In addition to the patient’s current medications, items of durable medical equipment (DME) can also be incorporated into the list. Hospital beds, respiratory equipment (e.g., nebulizers, CPAP, oxygen) and diabetes testing equipment and supplies are just some of the types of DME that can be monitored through this use of an “expanded” medication list. At each visit, just like with the medication list review, one can also note whether or not the patient continues to use their DME, ask if any additional supplies need to be ordered or refilled and how often they’re using the item, in the case of equipment such as glucose monitors or CPAP machines.

In the event of a record request from the medical equipment supplier to demonstrate continued usage, this Equipment/Medication List can be provided to support your patient’s claim for Medicare coverage.

For a complete list of LCDs and Policy articles please refer to DME Jurisdiction C website at http://www.cgsmedicare.com/jc/coverage/lcdinfo.html.

Thank you for your cooperation and your care of Medicare beneficiaries

Sincerely,

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
Noridian Healthcare Solutions

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

Stacey V. Brennan, MD, FAAFP
Medical Director, DME MAC, Jurisdiction B
CGS Administrators, LLC

Peter J. Gurk, MD, CPE, CHCQM
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions
Dear Physician:

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

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

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

Printable copies of CMNs and DIFs are available on the CMS website at [https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html](https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html). To find a CMN/DIF, enter the name or form number in the “Filter On” field. For instance, if you are searching for the Oxygen CMN, enter the word “oxygen” or “484”.

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

Sincerely,

Robert D. Hoover, Jr., MD, MPH, FACP
Senior Medical Director
CGS - Jurisdiction C DME MAC
New Physician Specialty Code for Hospitalist


MLN Matters® Number: MM9716 Revised
Related CR Release Date: November 25, 2016
Related CR Transmittal #: R3637CP and R276FM
Related Change Request (CR) #: CR 9716
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

Note: This article was updated on November 28, 2016, to reflect a revised CR9716, issued on November 25. 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, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background
When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes, which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claims processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:

- Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims
- Critical Access Hospital (CAH) Method II Attending and Rendering claims
- Attending, operating, or other physician or non-physician practitioner listed on CAH claims

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History
- November 28, 2016 – This article was updated to reflect a revised CR9716, issued on November 25. 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.
- October 28, 2016 – Initial issuance.
New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy


MLN Matters® Number: MM9726
Related CR Release Date: August 12, 2016
Related Change Request (CR) #: CR 9726
Effective Date: Effective Date: January 1, 2017
- Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service

Related CR Transmittal #: R3586CP
Implementation Date: January 3, 2017

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

Provider Action Needed
CR 9726 updates the Place of Service (POS) code set by creating a new code (POS 02) for Telehealth services, effective January 1, 2017. You should ensure that your billing staffs are aware of this new POS code.

Background
As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims.

As a payer, Medicare must be able to recognize, as valid, any valid code from the POS code set that appears on the HIPAA standard claim transaction. Further, unless prohibited by national policy to the contrary, Medicare not only recognizes such codes, but also adjudicates claims that contain these codes.

At times, Medicaid has had a greater need for code specificity than has Medicare; and many of the new codes, over the past few years, have been developed to meet Medicaid’s needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective January 1, 2017, CMS is creating a new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site. CR 9726 updates the current POS code set by adding this new code (POS 02: Telehealth), with a descriptor of “The location where health services and health related services are provided or received, through telecommunication technology.”

Medicare will pay for these services using the Medicare Physician Fee Schedule (MPFS),
including the use of the MPFS facility rate for Method II Critical Access Hospitals billing on type of bill 85x. This Telehealth POS code would not apply to originating site facilities billing a facility fee.

Remember that under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for Medicare Telehealth services. If you bill for Telehealth services with POS code 02, but without the GT or GQ modifier, your MAC will deny the service with the following messages:

- Group Code CO
- Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- Remittance Advice Remarks Code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information)

Conversely, if you bill for Telehealth services with modifiers GT or GQ, but without POS code 02, your MAC will deny the service with the following messages:

- Group Code CO
- CARC 5 (The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- RARC M77 (Missing/incomplete/invalid/inappropriate place of service)

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment


MLN Matters® Number: MM9848
Related CR Release Date: November 10, 2016
Related CR Transmittal #: R3649CP
Related Change Request (CR) #: CR 9848
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9848 updates Chapter 20, Section 130.6 of the “Medicare Claims Processing Manual” to provide additional instructions in processing claims for oxygen and oxygen equipment. Make sure that your billing staffs are aware of these changes.

Key Points of CR9848
The fee schedule amount for stationary oxygen equipment is increased under the following conditions. If both conditions apply, DME MACs use the higher of either of the following add-ons, but may not pay both add-ons:

Volume Adjustment
If the prescribed amount of oxygen for stationary equipment exceeds 4 liters per minute, the fee schedule amount for stationary oxygen rental is increased by 50 percent. If the prescribed liter flow for stationary oxygen is different than for portable or different for rest and exercise, DME MACs use the prescribed amount for stationary systems and for patients at rest. If the prescribed liter flow is different for day and night use, DME MACs use the average of the two rates.

Portable Add-on
If portable oxygen is prescribed, the fee schedule amount for portable equipment is added to the fee schedule amount for stationary oxygen rental.

The following HCPCS code modifiers should be used to denote when the oxygen flow exceeds 4 liters per minute:

- QF - Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed
- QG - Prescribed amount of oxygen is greater than 4 Liters Per Minute (LPM)

The modifier “QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 LPM.

Effective April 1, 2017, stationary and portable oxygen and oxygen equipment QF fee schedule amounts will be added to the DMEPOS fee schedule file. The stationary oxygen and oxygen equipment QF fee schedule amount on the file will represent 100 percent of the stationary oxygen and oxygen equipment allowed fee schedule amount. The portable oxygen equipment...
add-on QF fee schedule amount on the file by state will represent the higher of:

1. 50 percent of the monthly stationary oxygen payment amount (codes E0424, E0439, E1390, E1391) or
2. The fee schedule amount for the portable oxygen add-on (codes E0431, E0433, E0434, E1392 or K0738).

The following are possible claims processing scenarios:

Scenario 1 – A claim for stationary oxygen equipment is submitted with the QG modifier. Medicare reviews the history and discovers that portable oxygen equipment was billed AND paid within the last 30 days prior to the date of service for the stationary oxygen equipment. Since the portable oxygen equipment add-on payment has already been made for this month, the volume adjustment add-on payment shall not be made in accordance with the rules of the statute. Use of the QG modifier is inappropriate in this case, and the claim should be returned as unprocessable.

Scenario 2 – A claim for stationary oxygen equipment is submitted with the QG modifier, and within 30 days the beneficiary needs portable oxygen equipment. In this case, the volume add-on payment has already been made for this month, so the portable oxygen equipment add-on payment shall not be made in accordance with the rules of the statute. The claim for the portable oxygen equipment should be returned as unprocessable.

Scenario 3 – A claim for stationary oxygen equipment is submitted with the QG modifier AND a claim for portable oxygen equipment is submitted with the same date of service. In this case EVERYTHING is returned as unprocessable due to the incorrect use of the modifier, and neither the claim for stationary oxygen equipment with the QG modifier nor the claim for portable oxygen equipment is valid.

NOTE: All these claims are being returned as unprocessable since there is no way for Medicare to know whether the first submitted claim was billed incorrectly or the subsequent claim was billed incorrectly.

Unprocessable claims will be returned with the following messages:

- Group Code: CO (Contractual Obligation)
- Claim Adjustment Reason Code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)
Update to Medicare Deductible, Coinsurance and Premium Rates for 2017


MLN Matters® Number: MM9902
Related CR Release Date: December 2, 2016
Related CR Transmittal #: R103GI
Related Change Request (CR) #: CR 9902
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2017 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

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

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

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

2017 Part A - Hospital Insurance (HI)
- Deductible: $1,316.00
- Coinsurance
$329.00 a day for 61st-90th day
$658.00 a day for 91st-150th day (lifetime reserve days)
$164.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
• Base Premium (BP): $413.00 a month
• BP with 10 percent surcharge: $454.30 a month
• BP with 45 percent reduction: $227.00 a month (for those who have 30-39 quarters of coverage)
• BP with 45 percent reduction and 10 percent surcharge: $249.70 a month

2017 Part B - Supplementary Medical Insurance (SMI) : $249.70 a month
• Standard Premium: $134.00 a month
• Deductible: $183.00 a year
• Pro Rata Data Amount
  • $125.73 1st month
  • $57.27 2nd month
• Coinsurance: 20 percent

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

The Process of Prior Authorization


MLN Matters® Number: MM9940
Related CR Release Date: January 20, 2017
Related CR Transmittal #: R698Pi

Related Change Request (CR) #: CR 9940
Effective Date: February 21, 2017
Implementation Date: February 21, 2017

Provider Types Affected
This MLN Matters® Article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare Administrative Contractors (MACs) for items furnished to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) “Program Integrity Manual” to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017, Prior Authorization of Certain Durable Medical Equipment, Prosthetic, Orthotic, and Supply Items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.
**Background**

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare’s coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/documentation does not meet Medicare’s coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.
- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, Unique Tracking Number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

**Prior Authorization Program for DME MACs**

A prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the Prior Authorization Master List to be placed on the Required Prior Authorization List, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
The List of Required DMEPOS Prior Authorization Items contains those items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The List of Required DMEPOS Prior Authorization Items will be updated as additional codes are selected for prior authorization.

CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via Federal Register notice and posting on the CMS prior authorization website.


Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Extension of Payment Change for Group 3 Complex Rehabilitative Power Wheelchairs Accessories and Seat and Back Cushions under Section 16005 of the 21st Century Cures Act


MLN Matters® Number: MM9966
Related CR Release Date: February 3, 2017
Related CR Transmittal #: R3713CP
Related Change Request (CR) #: CR 9966
Effective Date: January 1, 2017
Implementation Date: April 3, 2017 - For VMS;
July 3, 2017 - For FISS

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for rehabilitative power wheelchairs, accessories and seat and back cushions paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

What You Need to Know
Change Request (CR) 9966 highlights Section 16005 of the 21st Century Cures Act. Section 16005 modifies Section 2(a) of the Patient Access and Medicare Protection Act (PAMPA) to require that the adjusted fee schedule amounts for 2017, described in Section 1834(a)(1)(F)(ii) of the Social Security Act, are not to be applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (described by HCPCS codes K0848 through K0864) prior to July 1, 2017.
• The codes for wheelchair accessories and seat and back cushions affected by the date extension change to July 1, 2017, are listed in Attachment A in CR9966 and also included in this article. Suppliers must use the KU modifier with the codes denoted in the attachment for claims submitted on or after January 1, 2017, for dates of service on or after January 1, 2017, and before July 1, 2017.

• The KU modifier and the unadjusted fee schedule amounts mandated for use in paying 2017 claims for these items are added to the January 2017 DMEPOS fee schedule file for the codes listed in Attachment A.

• The unadjusted 2016 KU fee schedule amounts were updated by the 0.7 percent 2017 covered item update.

Background
Transmittal 3671 dated December 5, 2016 (MLN Matters Article MM9854) provided instructions regarding the 2017 annual update for the DMPEOS fee schedule. Legislation effective January 1, 2017, requires changes to the 2017 fee schedule amounts for certain items. CR 9966 provides instructions regarding the implementation of the 2017 fee schedule amounts based on the changes mandated by Section 16005 of the 21st Century Cures Act.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain DME items furnished on or after January 1, 2016, including wheelchair accessories and seat and back cushions in areas that are not competitive bid areas, based on information from competitive bidding programs for DME. However, Section 2 of the PAMPA requires that the adjusted fee schedule amounts for 2016 not be applied to wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017.

CR9520 (Transmittal 3535, dated June 7, 2016 CR9520) and CR9586 (Transmittal 1671, dated June 2, 2016 CR9586) implemented this PAMPA provision and required the use of the KU modifier (DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3) to pay claims for dates of service on or after January 1, 2016, and before January 1, 2017.

The KU modifier and fee schedule amounts mandated for use in paying 2016 claims for wheelchair accessory or seat or back cushion when furnished in connection with a Group 3 complex rehabilitative power wheelchair were added to the 2016 DMEPOS fee schedule file. In accordance with the PAMPA provision, the KU fees were deleted from the DMEPOS fee schedule file effective January 1, 2017

Key Points
• Beginning January 1, 2017, through June 30, 2017, the 2017 unadjusted fee schedule amounts for the codes listed in Attachment A and associated with the KU modifier are included in the DMEPOS fee schedule file.

• Your MAC will process claims associated with the HCPCS codes that are eligible to use the KU modifier by applying the effective dates in a user controlled table so that the utilization of the KU modifier can be extended beyond the current end date of December 31, 2016.

• Your MAC will process claims using the 2017 unadjusted fee amounts for claims with the applicable HCPCS code, submitted with the “KU” modifier, for claims with dates of service between January 1, 2017 and prior to July 1, 2017.

Attachment A

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>HCPCS</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0705</td>
<td>Transfer device</td>
<td>E2386</td>
<td>Foam filled drive wheel tire</td>
</tr>
<tr>
<td>E0950</td>
<td>Tray</td>
<td>E2387</td>
<td>Foam filled caster tire</td>
</tr>
<tr>
<td>E0951</td>
<td>Loop heel</td>
<td>E2388</td>
<td>Foam drive wheel tire</td>
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<tr>
<td>HCPCS</td>
<td>Short Descriptor</td>
<td>HCPCS</td>
<td>Short Descriptor</td>
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<tr>
<td>E0952</td>
<td>Toe loop/holder, each</td>
<td>E2389</td>
<td>Foam caster tire</td>
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<tr>
<td>E0955</td>
<td>Cushioned headrest</td>
<td>E2390</td>
<td>Solid drive wheel tire</td>
</tr>
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<td>E0956</td>
<td>W/c lateral trunk/hip suppor</td>
<td>E2391</td>
<td>Solid caster tire</td>
</tr>
<tr>
<td>E0957</td>
<td>W/c medial thigh support</td>
<td>E2392</td>
<td>Solid caster tire, integrate</td>
</tr>
<tr>
<td>E0960</td>
<td>W/c shoulder harness/straps</td>
<td>E2394</td>
<td>Drive wheel excludes tire</td>
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<tr>
<td>E0973</td>
<td>W/Ch access det adj armrest</td>
<td>E2395</td>
<td>Caster wheel excludes tire</td>
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<tr>
<td>E0978</td>
<td>W/C acc,saf belt pelv strap</td>
<td>E2396</td>
<td>Caster fork</td>
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<tr>
<td>E0981</td>
<td>Seat upholstery, replacement</td>
<td>E2397</td>
<td>Pwc acc, lith-based battery</td>
</tr>
<tr>
<td>E0982</td>
<td>Back upholstery, replacement</td>
<td>E2601</td>
<td>Gen w/c cushion wdth &lt; 22 in</td>
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<tr>
<td>E0985</td>
<td>W/c seat lift mechanism</td>
<td>E2602</td>
<td>Gen w/c cushion wdth &gt;=22 in</td>
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<tr>
<td>E0990</td>
<td>Wheelchair elevating leg res</td>
<td>E2603</td>
<td>Skin protect wc cus wd &lt;22in</td>
</tr>
<tr>
<td>E0995</td>
<td>Wheelchair calf rest</td>
<td>E2604</td>
<td>Skin protect wc cus wd&gt;=22in</td>
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<tr>
<td>E1002</td>
<td>Pwr seat tilt</td>
<td>E2605</td>
<td>Position wc cush wd &lt;22 in</td>
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<td>Pwr seat recline</td>
<td>E2606</td>
<td>Position wc cush wd&gt;=22 in</td>
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<td>E1004</td>
<td>Pwr seat recline mech</td>
<td>E2607</td>
<td>Skin pro/pos wc cus wd &lt;22in</td>
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<td>Pwr seat recline pwr</td>
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<td>Pwr seat combo w/o shear</td>
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<td>Gen use back cush wd &lt;22in</td>
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<td>Pwr seat combo w/shear</td>
<td>E2612</td>
<td>Gen use back cush wd&gt;=22in</td>
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<tr>
<td>E1008</td>
<td>Pwr seat combo pwr shear</td>
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<td>Position back cush wd &lt;22in</td>
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<td>E1010</td>
<td>Add pwr leg elevation</td>
<td>E2614</td>
<td>Position back cush wd&gt;=22in</td>
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<td>E1012</td>
<td>Ctr mount pwr elev leg rest</td>
<td>E2615</td>
<td>Pos back post/lat wd &lt;22in</td>
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<td>E1016</td>
<td>Shock absorber for power w/c</td>
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<td>Pos back post/lat wd&gt;=22in</td>
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<td>Residual limb support system</td>
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<td>Replace cover w/c seat cush</td>
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<td>W/c manual swingaway</td>
<td>E2620</td>
<td>WC planar back cush wd &lt;22in</td>
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<tr>
<td>E1029</td>
<td>W/c vent tray fixed</td>
<td>E2621</td>
<td>WC planar back cush wd&gt;=22in</td>
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<td>E1030</td>
<td>W/c vent tray gimbaled</td>
<td>E2622</td>
<td>Adj skin pro w/c cus wd &lt;22in</td>
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<tr>
<td>E2207</td>
<td>Crutch and cane holder</td>
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<td>Adj skin pro w/c cus wd&gt;=22in</td>
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<td>E2208</td>
<td>Cylinder tank carrier</td>
<td>E2624</td>
<td>Adj skin pro/pos cus&lt;22in</td>
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<td>E2209</td>
<td>Arm trough each</td>
<td>E2625</td>
<td>Adj skin pro/pos wc cus&gt;=22</td>
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<td>E2210</td>
<td>Wheelchair bearings</td>
<td>E2626</td>
<td>Seo mobile arm sup att to wc</td>
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<tr>
<td>E2310</td>
<td>Electro connect btw control</td>
<td>E2627</td>
<td>Arm supp att to wc rancho ty</td>
</tr>
<tr>
<td>E2311</td>
<td>Electro connect btw 2 sys</td>
<td>E2628</td>
<td>Mobile arm supports reclinin</td>
</tr>
<tr>
<td>E2321</td>
<td>Hand interface joystick</td>
<td>E2629</td>
<td>Friction dampening arm supp</td>
</tr>
<tr>
<td>E2322</td>
<td>Mult mech switches</td>
<td>E2630</td>
<td>Monosuspension arm/hand supp</td>
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<tr>
<td>E2323</td>
<td>Special joystick handle</td>
<td>E2631</td>
<td>Elevat proximal arm support</td>
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<tr>
<td>E2324</td>
<td>Chin cup interface</td>
<td>E2632</td>
<td>Offset/lat rocker arm w/ela</td>
</tr>
<tr>
<td>E2325</td>
<td>Sip and puff interface</td>
<td>E2633</td>
<td>Mobile arm support supinator</td>
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<tr>
<td>E2326</td>
<td>Breath tube kit</td>
<td>K0015</td>
<td>Detach non-adjus hght armrst</td>
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<tr>
<td>E2327</td>
<td>Head control interface mech</td>
<td>K0017</td>
<td>Detach adjust armrest base</td>
</tr>
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<td>E2328</td>
<td>Head/extremity control inter</td>
<td>K0018</td>
<td>Detach adjust armrst upper</td>
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<td>E2329</td>
<td>Head control nonproportional</td>
<td>K0019</td>
<td>Arm pad each</td>
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<tr>
<td>E2330</td>
<td>Head control proximity swtch</td>
<td>K0020</td>
<td>Fixed adjust armrest pair</td>
</tr>
<tr>
<td>E2351</td>
<td>Electronic SGD interface</td>
<td>K0037</td>
<td>High mount flip-up footrest</td>
</tr>
<tr>
<td>E2359</td>
<td>Gr34 sealed leadacid battery</td>
<td>K0038</td>
<td>Leg strap each</td>
</tr>
</tbody>
</table>
HCPCS | Short Descriptor | HCPCS | Short Descriptor
--- | --- | --- | ---
E2360 | 22nf nonsealed leadacid | K0039 | Leg strap h style each
E2361 | 22nf sealed leadacid battery | K0040 | Adjustable angle footplate
E2362 | Gr24 nonsealed leadacid | K0041 | Large size footplate each
E2363 | Gr24 sealed leadacid battery | K0042 | Standard size footplate each
E2364 | U1nonsealed leadacid battery | K0043 | Frst lower extension tube
E2365 | U1 sealed leadacid battery | K0044 | Frst upper hanger bracket
E2366 | Battery charger, single mode | K0045 | Footrest complete assembly
E2367 | Battery charger, dual mode | K0046 | Elevat legrst low extension
E2368 | Power wc motor replacement | K0047 | Elevat legrst up hangr brack
E2369 | Pwr wc drivewheel gear repl | K0051 | Cam relese assem frst1/igrst
E2370 | Pwr wc motor/gear box combo | K0052 | Swingaway detach footrest
E2371 | Gr27 sealed leadacid battery | K0053 | Elevate footrest articulate
E2373 | Hand/chin ctrl spec joystick | K0056 | Seat ht <17 or >=21 ltwt wc
E2374 | Hand/chin ctrl std joystick | K0065 | Spoke protectors
E2375 | Non-expandable controller | K0069 | Rear whl complete solid tire
E2376 | Expandable controller, repl | K0070 | Rear whl compl pneum tire
E2377 | Expandable controller, initl | K0071 | Front castr compl pneum tire
E2378 | Pw actuator replacement | K0072 | Frnt cstr compl sem-pneum tir
E2381 | Pneum drive wheel tire | K0073 | Caster pin lock each
E2382 | Tube, pneum wheel drive tire | K0077 | Front caster assem complete
E2383 | Insert, pneum wheel drive | K0098 | Drive belt power wheelchair
E2384 | Pneumatic caster tire | K0105 | Iv hanger
E2385 | Tube, pneumatic caster tire | K0733 | 12-24hr sealed lead acid

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
CGS Announces the 2017 workshop series!

Suppliers always leave with new knowledge or a new approach to an existing problem back at the office.
MEDICAL POLICY

LCD and Policy Article Revisions Summary for December 29, 2016

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are External Infusion Pumps and Intravenous Immune Globulin. Please review the entire LCD and related PA for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2017

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
• Added: Denial verbiage for JW Modifier when coverage criteria not met

HCPCS MODIFIERS:
• Added: JW Modifier

DOCUMENTATION REQUIREMENTS:
• Added: JW Modifier instructions

Policy Article

Revision Effective Date: 07/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
• Revised: Language regarding payment rules for infusion drugs started in a physician's office or hospital outpatient department. – Effective 4/25/2016

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2017

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
• Added: Denial language for JW Modifier when coverage criteria not met

HCPCS MODIFIERS:
• Added: JW Modifier

DOCUMENTATION REQUIREMENTS:
• Added: JW Modifier instructions

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

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.
DME MACs LCD Format Change

- DME MAC Joint Publication

The DME MACs will be revising the DOCUMENTATION REQUIREMENTS section of all Local Coverage Determinations (LCDs) during our CMS-required annual LCD review. The LCD updates will be published in early 2017.

Historically, our LCDs focused on criteria necessary to determine that an item was reasonable and necessary. The DOCUMENTATION REQUIREMENTS section provided information related to the documentation of key policy-related payment rules, and suppliers were referred to the DME MACs Supplier Manuals for detailed discussion of documentation requirements associated with each payment rule.

Medicare contractor audits, including CERT audits, have demonstrated numerous errors associated with incomplete or missing documentation. In response to these audit findings, starting in 2011, the DME MACs expanded the DOCUMENTATION REQUIREMENTS sections to provide detailed information on each key payment rule. These documentation requirements were compiled from Statutes, Code of Federal Regulations, CMS manuals, supplier manuals, and DME MAC publications. The goal was to create a standardized set of requirements to assist DMEPOS suppliers in understanding the information necessary to justify payment, and lower the improper payment rate.

Over time, the administrative burden of maintaining these policies has dramatically increased. Even a minor change necessitates the updating of over 50 individual LCDs and their LCD related Policy Articles, with attendant risks of introducing clerical errors.

Thus, in 2017, we will be reverting back to the previous LCD format that existed prior to 2011, and general documentation requirements that have appeared within individual policies (LCDs) will be removed from all DME MAC LCDs. The general documentation requirements will thereafter be located in a separate Standard Documentation Requirements LCD related Policy Article in the Medicare Database, which will be linked to all DME MAC LCDs.

In addition to the general documentation requirements, LCDs often contain documentation requirements that are unique to that specific policy. These requirements are termed “POLICY SPECIFIC DOCUMENTATION REQUIREMENTS”. Historically, these requirements have appeared within the individual LCD DOCUMENTATION REQUIREMENTS section. Such information will be removed from all LCDs and will be moved to the LCD related Policy Article in the Medicare Database, which is currently linked to the applicable LCD.

It is important that suppliers review the LCD, the LCD related Policy Article, and the LCD related Standard Documentation Requirements Article, to ensure that they have all of the relevant information necessary and applicable to the item(s) provided.

Suppliers are reminded that these changes in the LCD format do not add any new requirements, nor remove any existing Medicare documentation requirements. In the event of a claim review (audit), the LCD format change does not obviate a supplier’s obligation to provide sufficient documentation to demonstrate compliance with Medicare payment rules.
Coding and Coverage – Therapeutic Continuous Glucose Monitors (CGM)

On December 20, 2016 the Food & Drug Administration (FDA) granted premarket approval to Dexcom, Inc. for an expanded indication for their Dexcom G5® Mobile Continuous Glucose Monitoring (CGM) System. The Dexcom G5® Mobile CGM System is now indicated to replace fingerstick blood glucose monitor (BGM) testing for diabetes treatment decisions, referred to by the FDA as “non-adjunctive” use. The Dexcom G5® Mobile CGM System is currently the only FDA-approved device with a “non-adjunctive” indication.

On January 12, 2017 the Centers for Medicare & Medicaid Services (CMS) issued CMS Ruling 1682R addressing the benefit category for non-adjunctive CGM systems. CMS Ruling 1682R classified CGM systems into therapeutic and non-therapeutic systems. Therapeutic CGM are defined as CGM used as a replacement for fingerstick blood glucose testing for diabetes treatment decisions i.e., non-adjunctive use. Non-therapeutic CGM are devices used as an adjunct to BGM testing (i.e., primary therapeutic decisions regarding diabetes treatment must be made with a standard home BGM, not the CGM).

The Ruling does not directly establish Social Security Act §1862(a)(1)(A) “reasonable and necessary” (medical necessity) or HCPCS coding requirements for therapeutic CGM but instructs the DME MAC contractors to make payment determinations on a claim-by-claim basis. This article provides interim instructions for individual claim adjudication, effective for claims with dates of service on or after January 12, 2017.

Benefit Category

CMS Ruling 1862R recognizes that therapeutic CGMs are durable medical equipment (DME) under section 1861(n) of the Act; therefore, they fall within the scope of Medicare Part B benefits. As of the publication date of this article, the Dexcom G5® Mobile CGM System is the only device which meets the therapeutic CGM device classification established by CMS Ruling 1862R. Refer to the Pricing, Data Analysis, and Coding (PDAC) contractor for information concerning which other devices may qualify under this ruling.

Interim Instructions for Individual Claim Adjudication

HCPCS Coding

For purposes of Medicare billing, the Ruling outlines therapeutic CGM as comprising two elements: (1) a DME component and, (2) an all-inclusive supply allowance. The DME component for the Dexcom G5® Mobile CGM system is the receiver. The receiver must be billed using the following code:

E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

When billing this code, suppliers must enter “Dexcom G5® Receiver” in the narrative field of the claim.

The supply allowance for supplies used with the Dexcom G5® Mobile CGM System encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home blood glucose monitor and related BGM supplies (test strips, lancets, lancing device, and calibration solutions) and all batteries. The supply allowance must be billed using the following code:
A9999 – DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS SUPPLY

Claims for A9999 must be billed as one (1) unit of service per month. When billing this code, suppliers must enter “Supplies used with Dexcom G5® Receiver” in the narrative field on the claim.

Smart Device Usage

The Medicare DME Benefit excludes coverage for non-medical items, even when the items may be used to serve a medical purpose. As a result, smart devices (smart phones, tablets, personal computers, etc.) are non-covered by Medicare under this exclusion. Likewise, medical supplies used with non-covered equipment are not eligible for Medicare reimbursement.

In addition to the DME receiver included in the Dexcom G5® Mobile CGM System, an alternative option for displaying the received data is with a smart device using the Dexcom G5® app and a beneficiary-owned smart device such as a smart phone or tablet. Medicare does not cover a beneficiary-owned smart device. Claims for beneficiary-owned smart devices submitted to Medicare must be coded:

A9270 - NONCOVERED ITEM OR SERVICE

Miscellaneous

Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers who provide the Dexcom G5® Mobile CGM System are reminded of the following Medicare coverage policies:

- Coverage of the CGM system supply allowance is limited to those therapeutic CGM systems where the beneficiary ONLY uses a receiver classified as DME to display glucose data. If a beneficiary uses a non-DME device (smart phone, tablet, etc.) as the display device, either separately or in combination with a receiver classified as DME, the supply allowance is non-covered by Medicare.

- Therapeutic CGM devices replace a standard home blood glucose monitor (HCPCS codes E0607, E2100, E2101) and related supplies (HCPCS codes A4233-A4236, A4244-A4247, A4250, A4253, A4255-A4259). Claims for standard home glucose monitors and all related supplies, billed in addition to a CGM system and associated supply allowance, will be denied as unbundling.

All non-therapeutic CGM systems must be billed with the existing CGM-related HCPCS codes. At this time, all CGM systems except the Dexcom G5® Mobile CGM System are classified by CMS as non-therapeutic CGM systems. All non-therapeutic CGM systems must be billed using the following codes:

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

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

A9278 - RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

These codes are non-covered by Medicare (no benefit).

Beneficiary-owned Equipment Retained from a Prior Payer

There is no “grandfathering” of equipment or supplies/accessories for CGM systems obtained prior to Medicare eligibility. When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare Fee-For-Service
program, the first Medicare claim for that item or service is considered a new initial Medicare claim. Even if there is no change in the beneficiary’s medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, should the supply or accessory have additional, separate criteria, these must also be met. For beneficiaries that have a Dexcom G5® Mobile CGM System who meet the coverage requirements outlined in this article, Medicare will provide reimbursement for the monthly supply allowance.

In the event of a Medicare contractor claim review, suppliers must provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the coverage guidance in this article for additional information.

**Patient Selection Criteria**

A framework for basic medical indications is set out in the “Conclusion” section of CMS Ruling 1682R which states (in relevant part):

**CONCLUSION**

For CGM products that are used in the home and approved by the FDA for use in place of a blood glucose monitor for making diabetes treatment decisions, these therapeutic CGMs are primarily and customarily used to serve a medical purpose because they are used by Medicare beneficiaries with diabetes who must measure their glucose level frequently and check trends in their glucose measurements for the purpose of adjusting their diet and insulin in the treatment of their diabetes. ... A receiver (or type of monitor) for a therapeutic CGM that has an expected life of at least 3 years and is the component performing the medically necessary function of accurately monitoring the trends of the patients’ blood glucose levels so that he or she can make necessary diabetes treatment decisions meets the 3-year MLR [minimum lifetime requirements]. [Emphasis added]

These statements provide a framework for determining which Medicare beneficiaries may receive a CGM device. A therapeutic CGM may be covered by Medicare when all of the following criteria are met:

- The beneficiary has diabetes mellitus; and,
- The beneficiary has been using a home blood glucose monitor (BGM) and performing frequent (four or more times a day) BGM testing; and,
- The beneficiary is insulin-treated with multiple daily injections (MDI) of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
- The beneficiary’s insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of therapeutic CGM testing results.

**Glucose Monitors LCD and related PA Revision**

The Glucose Monitors Local Coverage Determination (LCD) and related Policy Article (PA) will be updated in a future revision to incorporate the criteria outlined above. Policy-Specific Documentation Requirements and Coding Guidelines addressing CGM systems will also be added to the Glucose Monitors LCD-related PA. Because CMS did not provide coverage for CGM prior to the Ruling, the Glucose Monitors LCD and related PA represents a liberalization of coverage. Therefore, when the revised LCD is published, per the CMS Program Integrity Manual (Internet-Only Manual 100-08), Chapter 13, §13.7.3, no formal comment and notice period or public meeting is required.

The Program Integrity Manual section states, in relevant part:
13.7.3 - LCDs That Do Not Require a Comment and Notice Period

When a comment and notice period is unnecessary, contractors may immediately publish a revised LCD electronically (e.g., Medicare coverage database, contractor Web site, email). In the following situations, the comment and notice processes are unnecessary:

- Revised LCD that Liberalizes an Existing LCD - For example, a revised LCD expands the list of covered indications/diagnoses. The revision effective date may be retroactive.
- Revised LCD that Makes a Non-disccretionary Coverage/Payment/Coding Updates - Contractors shall update LCDs to reflect changes in NCDs, coverage provisions in interpretive manuals, payment systems, HCPCS, ICD-9 or other standard coding systems within the timeframes listed in §13.4C. The revision effective date may be retroactive depending on the effective date of the NCD, etc.

The Glucose Monitors LCD and related PA revisions will be retroactive to the effective date of the CMS Ruling (January 12, 2017).

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

ICD-10 Coding Revisions to National Coverage Determination (NCDs)

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<td>Related Change Request (CR) #: CR 9861</td>
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<tr>
<td>Related CR Release Date: February 3, 2017</td>
<td>Effective Date: October 1, 2016 - Unless otherwise noted in individual requirements</td>
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<tr>
<td>Related CR Transmittal #: R1792OTN</td>
<td>Implementation Date: March 3, 2017 - MAC local systems; April 3, 2017 - FISS, MCS, CWF Shared systems</td>
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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9861 is the 10th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, CR9540, CR9631, and CR 9751; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751 contain information pertaining to these CR’s.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based...
on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9861 makes adjustments to the following 16 NCDs:

- NCD 40.1 - Diabetes Outpatient Self-Management Training
- NCD 40.7 - Outpatient Intravenous Insulin Treatment
- NCD 80.2 - Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1)
- NCD 80.11 - Vitrectomy
- NCD 100.1 - Bariatric Surgery
- NCD 110.4 – Extracorporeal Photopheresis
- NCD 110.18 - Aprepitant
- NCD 110.23 - Stem Cell Transplantation
- NCD 180.1 - Medical Nutrition Therapy
- NCD 190.1 – Histocompatibility Testing
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammograms
- NCD 220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD 260.3.1 - Islet Cell Transplants
- NCD 260.5 - Intestinal and Multi-Visceral Transplants
- NCD 270.6 - Infrared Therapy Devices


You should remember that coding and payment areas of the Medicare Program are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Code (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119, with Group Code PR (Patient Responsibility) or Group Code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision

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

What You Need to Know
Change Request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR9708 updates Chapter 3, Section 90 of the “Medical Financial Management Manual.” Make sure your billing staff is aware of these updates.

Background
Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
- The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
- CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
- The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
- The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional Information
The official instruction, CR9708, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM.pdf. The revised Chapter 3, Section 90, of the manual is attached to CR9708.
If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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

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**MLN Matters® Number:** MM9769  
**Related CR Release Date:** November 18, 2016  
**Related CR Transmittal #:** R3661CP  
**Related Change Request (CR) #:** CR 9769  
**Effective Date:** April 1, 2017  
**Implementation Date:** April 3, 2017

**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**  
Change Request (CR) 9769 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

**Background**  
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.


Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9769.
**Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)**


**Related CR Release Date:** November 23, 2016
**Related CR Transmittal #:** R3665CP
**Related Change Request (CR) #:** CR 9767
**Effective Date:** April 1, 2017
**Implementation Date:** April 3, 2017

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

**Provider Action Needed**
Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

**Background**
The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE EFT & ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the 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.

CR9767 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2017. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


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 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 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 https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update


MLN Matters® Number: MM9774
Related CR Release Date: November 18, 2016
Related CR Transmittal #: R3660CP
Related Change Request (CR) #: CR 9774
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

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
Change Request (CR) 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

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

The Centers for Medicare & Medicaid Services (CMS) instructs contractors to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CMS provides this CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).

Additional Information
The official instruction, CR9774, issued to your MAC regarding this change, is available at
If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of Qualified Medicare Beneficiaries (QMBs) for Medicare Cost-Sharing


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<th>Related Change Request (CR) #: CR 9817</th>
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<tr>
<td>Related CR Release Date: November 18, 2016</td>
<td>Effective Date: December 16, 2016</td>
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<tr>
<td>Related CR Transmittal #: R1757OTN</td>
<td>Implementation Date: March 8, 2017</td>
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Note: This article was revised on November 18, 2016, to reflect the revised CR9817 issued that same day. In the article, the effective date, CR release date, transmittal number, and the Web address for CR9817 are revised. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums. All other information remains the same.
Provider Types Affected
This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to certain Medicare beneficiaries.

Provider Action Needed
Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Change Request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. Please make sure your billing staffs are aware of this aspect of your Medicare provider agreement.

Background
In 2013, approximately seven million Medicare beneficiaries were enrolled in QMB, a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost sharing.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost sharing. However, federal law permits states to limit provider payment for Medicare cost sharing to the lesser of the Medicare cost sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service provided. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions, as described in Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); and 1848(g)(3) of the Social Security Act (the Act).

In July 2015, the Centers for Medicare & Medicaid Services issued a study finding that:
- Erroneous billing of QMB individuals persists
- Confusion about billing rules exists amongst providers and beneficiaries

Note: The study, titled “Access to Care Issues Among Qualified Medicare Beneficiaries (QMB),” is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

In September 2016, all Medicare beneficiaries received “Medicare & You 2017,” which contains new language to advise QMB individuals about their billing protections. Also, a toll-free number (1-800-MEDICARE) is available to QMB individuals if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) can identify a caller’s QMB status and advise them about their billing rights.

BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC. MACs will issue a compliance letter for all inquiries referred. This compliance letter will instruct named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing (including referrals to collection agencies).

MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem. Examples of these letters are included following the “Document History” section of this article.
Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History

- November 18, 2016 - The effective date, CR release date, transmittal number, and the Web address for CR9817 are revised in the article due to a revised CR9817. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums.
- November 4, 2016 - Initial Issuance

Example of Cover Letter for affected QMB Individuals sent by MAC

[month] [day], [year]  
[address]  
[City] ST [Zip]  
Reference ID: (NPI, etc.)  
Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare premiums and costs. Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.

The letter tells the provider to stop billing you and to refund you any amounts you already paid. Here's what you can do:

1. Show this letter to your provider to make sure they fixed your bill.
2. Tell all of your providers and suppliers you are in the QMB program.
3. Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,

[Name]  
[Title]  
[MAC name]
Example of Compliance Letter Sent to Provider by the MAC

[month] [day], [year]

[address]
[City] ST [Zip]

Reference ID: (NPI, etc.)
Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare premiums and cost-sharing. Federal law says Medicare providers can’t charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

- Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf). If you have questions, please contact [MAC information].

Sincerely,

[Name]
[Title]
[MAC name]
New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)

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) 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual’s future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background
CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment “has been made or can reasonably be expected to be made under a workers’ compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment “has been made” for such items or services through use of LMSA or NFMSA funds. However, Liability and No- Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893
Medicare will not pay for those services related to the diagnosis code (or related within the
family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim's date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code "PR" will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an "N" on the '001' Total revenue charge line of the claim.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System


MLN Matters® Number: MM9911
Related CR Release Date: February 3, 2017
Related CR Transmittal #: R3715CP
Related Change Request (CR) #: CR 89911
Effective Date: for claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

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

Provider Action Needed
Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers’ ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare’s claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background
QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers’ ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient’s QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the “Medicare
Claims Processing Manual” to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare’s Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).

- CWF will provide the claims processing systems the QMB indicator if the “through date” falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary’s QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a Claim Adjustment Reason Code of 209 (“Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information


For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the MLN Matters article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

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Revised Centers for Medicare & Medicaid Services (CMS) 855S Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers


MLN Matters® Number: SE17004
Related CR Release Date: January 5, 2017
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: January 1, 2017
Implementation Date: December 31, 2016

Provider Types Affected

This MLN Matters® Article is intended for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) informs DMEPOS suppliers that they must use the revised CMS-855S (Medicare Enrollment Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers) application beginning December 31, 2016.

CAUTION – What You Need to Know

The revised application will be posted on the CMS Forms List (go.usa.gov/cuu5Y) by mid-summer. The National Supplier Clearinghouse (NSC) MAC may accept both the current and revised versions of the CMS-855S through December 31, 2016, after which the revised CMS-855S application must be submitted. After December 31, 2016, the NSC MAC will return any newly submitted CMS-855S applications using the previous version (01/13) to the supplier with a letter explaining that the CMS-855S has been updated and the current version of the CMS-855S (05/16) must be submitted.

GO – What You Need to Do

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

Background

DMEPOS suppliers must use the revised CMS-855S application starting December 31, 2016.

This revision of the CMS 855S simplifies and clarifies the current data collection and removes obsolete and/or redundant data collection. Grammar and spelling errors were corrected as well. Limited informational text has been added within the application form. In addition, links to websites are added to provide helpful instructions when greater detail is needed by the supplier, for example:

- The “Process to Obtain Medicare Approval” section of the instructions added the application fee and fingerprinting requirements, complete with website links and a telephone number for additional information, if the supplier desires additional information;
A note was added instructing non-profit government agencies that they need not submit an IRS Form 501(c)(3) to prove its non-profit status in sections 2, 8, and 12; and

CMS added a website offering guidance on DMEPOS supplier licensure requirements in Section 2.

To clarify current data collection, Section 3D (Products and Services Furnished by This Supplier) is updated to differentiate between used and new equipment for support surfaces, creating an option for the DMEPOS supplier to indicate whether the supplier provides new or used support surfaces, rather than having one category for both new and used (as on the previous version of the CMS 855S). In addition, “Hemodialysis Equipment and/or Supplies” and “Home Dialysis Equipment and/or Supplies” have been deleted from this section as they are only payable to Home Dialysis facilities which are solely a Part A benefit. “External Infusion Pumps and/or Supplies” as well as “Insulin Infusion Pumps and/or Supplies” have been split into two separate products - the pump itself and the supplies independent of the pump. The previous product categories were misleading because the supplier may not supply both products. “Invasive Mechanical Ventilation Devices” were replaced with the more accurate “Ventilators: All Types – Not CPAP or RAD” and the word “repairs” was added to the standard manual and standard power wheelchair accessories product categories in order to be more in sync with accreditation coding.

No additional material data collection has been added in this revision.

Additional Information
Visit the Medicare Provider Supplier Enrollment webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html for more information.
July 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

FEES & PRICING


MLN Matters® Number: MM9612
Related CR Release Date: April 22, 2016
Related CR Transmittal #: R3494CP

Related Change Request (CR) #: CR 9612
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

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

Provider Action Needed
Change Request (CR) 9612 informs MACs to download and implement the July 2016 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the April 2016, January 2016, October 2016 and July 2015, 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 July 5, 2016, with dates of service July 1, 2016, through September 30, 2016. Make sure that your billing staffs are aware of these changes.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital, Part B and OPPS)), Section 50 (Outpatient PRICER)).

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
</tr>
<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
</tbody>
</table>

Additional Information
The official instruction, CR 9612 issued to your MAC regarding this change is available at
If you have any questions, please contact your MAC at their toll-free number. That number is available at CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

October 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files


MLN Matters® Number: MM9724
Related CR Release Date: July 29, 2016
Related CR Transmittal #: R3573CP
Related Change Request (CR) #: CR 9724
Effective Date: October 1, 2016
Implementation Date: October 3, 2016

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.

What You Need to Know
Change Request (CR) 9724 provides the October 2016 quarterly update and instructs MACs to download and implement the October 2016 ASP drug pricing files and, if released by CMS, the July 2016, April 2016, January 2016, and October 2015, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 3, 2016, with dates of service October 1, 2016, through December 31, 2016. 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 ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Medicare Claims Processing Manual” at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

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

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<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016 ASP and ASP NOC</td>
<td>October 1, 2016, through December 31, 2016</td>
</tr>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</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.

CY 2017 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule


MLN Matters® Number: MM9854
Related CR Release Date: December 5, 2016
Related CR Transmittal #: R3671CP
Related Change Request (CR) #: CR 9854
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

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

What You Need to Know
Change Request (CR) 9854 provides the calendar year (CY) 2017 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background
The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in Chapter 23 Section 60 in the “Medicare Claims Processing Manual.”

Payment on a fee schedule basis is required for certain durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician’s office.

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral...
nutrition) based on information from CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). Also, program instructions on these changes are available in Transmittal 3551, CR 9642 (MLN Matters article MM9642), dated June 23, 2016, and Transmittal 3416, CR 9431 (MM9431), dated November 23, 2015.

The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR 414.210(g)(8) when information from the CBPs is updated. This update to the adjusted fees includes information from the CBPs that takes effect on January 1, 2017 (Round 1 2017). Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2017 for this update) and for each subsequent year such as 2018 and 2019.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Regulations at Section 414.202 define rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

Policy: Fee Schedule and Rural Zip Code Files
The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for both enteral nutrition items and national non-rural fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS DMEPOS fee schedule website after November 18, 2016.

New Codes Added
The new codes are not to be used for billing purposes until they are effective on January 1, 2017. For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2016 by payment category are in the table below.

<table>
<thead>
<tr>
<th>Code Description</th>
<th>Deflation Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>0.454</td>
</tr>
<tr>
<td>Capped Rental</td>
<td>0.457</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>0.458</td>
</tr>
<tr>
<td>Surgical Dressings</td>
<td>0.582</td>
</tr>
<tr>
<td>Parental and Enteral Nutrition</td>
<td>0.633</td>
</tr>
<tr>
<td>Splints and Casts</td>
<td>0.969</td>
</tr>
<tr>
<td>Intraocular Lenses</td>
<td>0.952</td>
</tr>
</tbody>
</table>

Codes Deleted
Codes deleted from the DMEPOS fee schedule files effective January 1, 2017, are:

- B9000 - Enteral nutrition infusion pump - without alarm (Enter infusion pump w/o alrm)
- B9000MS - Enteral nutrition infusion pump - without alarm
- E0628 - Separate seat lift mechanism for use with patient owned furniture-electric (Seat lift for pt furn-electr)
- 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 (Ko single upright pre ots)

- 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 (Ko double upright pre ots)

Effective January 1, 2017, codes B9000 and E0628 will crosswalk to codes B9002 and E0627 respectively. Payment for necessary maintenance and servicing of B9000 pumps will also crosswalk to B9002MS.

Effective January 1, 2017, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file.

The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 Transmittal 3535, CR 9520, dated June 7, 2016.

Specific Coding and Pricing Issues

Effective January 1, 2017, existing off-the-shelf orthotic (OTS) codes K0901 and K0902 are re-designated as codes L1851 and L1852 respectively. The fee schedule amounts for codes K0901 and K0902 will be applied to the corresponding new codes L1851 and L1852 as part of this update. Attachment B in CR 9854 updates the list of orthotic codes that are designated as OTS on the CMS orthotics website to reflect the addition of the two renumbered codes (L1851 and L1852).

As part of this update, the adjusted fee schedule amounts for the following groups of similar items are adjusted in accordance with 42 CFR Section 414.210 (g)(6) to limit the single payment amounts (SPAs) for items without certain features to the weighted average of the SPAs for the items both with and without the features prior to using the SPAs in adjusting the fee schedule amounts:

2. Mattress and overlays (HCPCS codes E0277, E0371, E0372, and E0373)
3. Power wheelchairs (HCPCS codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, and K0823)
4. Seat lift mechanisms (HCPCS codes E0627 and E0629)
5. TENS devices (HCPCS codes E0720 and E0730)
6. Walkers (HCPCS codes E0130, E0135, E0141 and E0143)

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

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

For 2017, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2015. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2017.
Diabetic Testing Supplies

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

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are Transmittal 2709, CR 8325 (MM8325), dated May 17, 2013, and Transmittal 2661, CR 8204 (MM8204), dated February 22, 2013. Note that the mail order DTS (KL) fee schedule amounts for all states and territories were removed from the DMEPOS fee schedule file as part of the July 1, 2016, update.

2017 Fee Schedule Update Factor of 0.7 Percent

For CY 2017, an update factor of 0.7 percent is applied to certain DMEPOS fee schedule amounts.

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2017 by the percentage increase in the consumer price index for all urban consumers (United States city average) or urban consumers (CPI-U) for the 12-month period ending with June of 2016, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.3 percent and the CPI-U percentage increase is 1 percent. Therefore, the 1 percentage increase in the CPI-U is reduced by the 0.3 percentage increase in the MFP resulting in a net increase of 0.7 percent for the update factor.

2017 Update to the Labor Payment Rates

Included below and in Attachment A in CR9854 are the CY 2017 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the twelve month period ending with June 30, 2016, is 1 percent, this change is applied to the 2016 labor payment amounts to update the rates for CY 2017. The 2017 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2017, through December 31, 2017.

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
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<th>L7520</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
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<td>AL</td>
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<td>$22.38</td>
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<td>AZ</td>
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<td>CA</td>
<td>$23.04</td>
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<td>CO</td>
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2017 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

As part of this update, CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2017, through December 31, 2017. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes. Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2017, through December 31, 2017, the 2017 monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $67 to $77, incorporating the budget neutrality adjustment factor.

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

2017 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2017 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6972 (MM6972), dated February 5, 2010 and Transmittal 717, CR6990 (MM6990), dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months, beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for HCPCS codes E1390, E1391, E0433 or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Therefore, the 2016 maintenance and servicing fee is adjusted by the 0.7 percent MFP-adjusted covered item update factor to yield CY 2017 maintenance and servicing fee of $69.97 for oxygen concentrators and transfilling equipment.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at MAC Toll-Free Number under - How Does It Work.

For more information regarding the Competitive Bidding Implementation Contractor website refer to the CBIC website.
April 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files


MLN Matters® Number: MM9945  Related Change Request (CR) #: CR 9945
Related CR Release Date: January 13, 2017  Effective Date: April 1, 2017
Related CR Transmittal #: R3692CP  Implementation Date: April 3, 2017

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.

What You Need to Know
Change Request (CR) 9945 provides the April 2017 quarterly update and instructs MACs to download and implement the April 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised January 2017, October 2016, July 2016, and April 2016 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 April 3, 2017, with dates of service April 1, 2017, through June 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

For claims with a date of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, which was signed into law on December 13, 2016, payment for infusion drugs furnished through a covered item of Durable Medical Equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the ASP of these drugs. Payment for DME infusion drugs that do not appear on the ASP Drug Pricing Files will be determined by the MACs in accordance with the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. Make sure your billing staffs are aware of these changes.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Medicare Claims Processing Manual” at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

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

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**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

**HCPCS UPDATES**

**Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement**

**Link to current version on the CMS website:** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9771.pdf

**MLN Matters® Number:** MM9771 Revised  
**Related CR Release Date:** October 7, 2016  
**Related CR Transmittal #:** R3618CP  
**Related Change Request (CR) #:** CR 9771  
**Effective Date:** January 1, 2017  
**Implementation Date:** January 3, 2017

**Note:** This article was revised on January 12, 2017, to correct in the table on page 2. The table incorrectly listed HCPCS code 97177. The correct HCPCS code is HCPCS 97167 (OT EVAL HIGH COMPLEX 60 MIN). All other information is unchanged.

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

**Provider Action Needed**

Change Request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

**Background**

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are
submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

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G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Document History**

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<tr>
<td>11/17/2016</td>
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The most detailed MR denial and ADR status information available anywhere!
2017 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List

MLN Matters® Number: MM9903 Revised
Related CR Release Date: January 5, 2017
Related CR Transmittal #: R3689CP
Related Change Request (CR) #: CR 9903
Effective Date: January 1, 2017
Implementation Date: January 24, 2017

Note: This article was revised on January 6, 2017, to reflect the revised CR9903 issued on January 5. 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 providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What You Need to Know
Change Request (CR) 9903 notifies suppliers that the spreadsheet containing the jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the “Medicare Claims Processing Manual” are reflected in the recurring update notification. The document for the 2017 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html and is also attached CR9903.

Additional Information
The official instruction, CR9903, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3689CP.pdf. If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/monitoring-programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

Document History
• January 6, 2017 - Article revised to reflect revised CR9903. 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.
• December 26, 2016 - Initial Issuance
COMPETITIVE BIDDING

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2017


MLN Matters® Number: MM9792 Revised  
Related CR Release Date: November 25, 2016  
Related CR Transmittal #: R3668CP

Related Change Request (CR) #: CR 9792  
Effective Date: January 1, 2017  
Implementation Date: January 3, 2017

Note: This article was revised due to a revised CR9792, issued on November 25, 2016. The CR was revised to provide an explanation regarding a few changes that have occurred in the 2017 HCPCS file. These changes are noted in the paragraph just prior to the Additional Information section of this article. The CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.

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

What You Need to Know
Change Request (CR) 9792 provides the January 2017 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR9792 to provide the DMEPOS CBP January 2017 quarterly update.

CR9701 provides specific instructions to your Durable Medical Equipment (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 available on the DMEPOS Competitive Bidding Program (CBP) website.

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

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

To reflect changes in the 2017 HCPCS file, the HCPCS codes and single payment amounts for B9000, B9000MS and E0628 will be removed from the competitive bidding files, effective January 1, 2017. HCPCS codes B9000, B9000MS and E0628 crosswalk to HCPCS codes B9002, B9002MS and E0627, respectively.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

The DMEPOS CBP site (http://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home) includes information on all rounds of the CBP, including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

Document History
• November 28, 2016 – The article was revised due to a revised CR9792. The CR was revised to provide an explanation regarding a few changes that have occurred in the 2017 HCPCS file. These changes are noted in the paragraph just prior to the Additional Information section above.
• October 28, 2015 – Initial issuance.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program — April 2017


MLN Matters® Number: MM9971
Related CR Release Date: February 3, 2017
Related CR Transmittal #: R3702CP

Related Change Request (CR) #: CR 9971
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

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

Change Request (CR) 9971 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR9771 to provide the DMEPOS Competitive Bidding Program (CBP) April 2017 quarterly update.

CR9971 provides specific instructions to your Durable Medical Equipment (DME) MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. DMEPOS CBP quarterly updates are available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home. At the site, click on the quarterly updates link on the left side of the page.

Background

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

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

Additional Information


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Mon - Fri, 8:00 a.m. - 6:00 p.m. CT |
| Paper Claim Submission                                 | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
IVR (Interactive Voice Response): 1.866.238.9650  
Mon - Fri, 6:00 a.m. - 8:00 p.m. CT;  
Sat, 6:00 a.m. - 4:00 p.m. CT  
Customer Service: 1.866.270.4909  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT  
Hearing Impaired: 1.888.204.3771  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT |
| Provider Customer Service Calls                        | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
Fax (for underpayments): 1.615.782.4649  
Fax (for overpayments): 1.615.782.4477  
Telephone requests for Reopenings: 1.866.813.7878  
Mon - Fri, 7:00 a.m. - 5:00 p.m. CT |
| Beneficiary Customer Service Calls                     | Phone: 1.800.Medicare  
E-mail: CGS.Medicare.OPID@cgsadmin.com |
| Written Inquiries                                      | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
Fax: 1.615.782.4630 |
| Claim Reopenings (Adjustments)                         | Address: CGS - Jurisdiction C  
PO Box 20010  
Nashville, TN 37202  
Enrollment Status: 1.866.270.4909 |
| Claim Status Inquiry                                   | Security Access Issues/Password Reset,  
E-mail: CGS.Medicare.OPID@cgsadmin.com |
| Appeals – Redetermination Requests                    | Address: CGS - Jurisdiction C  
PO Box 20009  
Nashville, TN 37202  
Fax: 1.615.782.4630 |
| Electronic Funds Transfer                              | Address: CGS  
Attn: EFT-DME  
PO Box 20010  
Nashville, TN 37202 |
| Refunds                                                | Address: CGS  
DME MAC Jurisdiction C  
PO Box 955152  
St. Louis, MO 63195-5152 |
| Overnight or Special Shipping                          | Address: CGS  
DME MAC Jurisdiction C  
Two Vantage Way  
Nashville, TN 37228 |
| DME MAC Jurisdiction C Website                        | Website: http://www.cgsmedicare.com/jc/index.html |
| Advance Determination of Medicare Coverage (ADMC) - Requests | Address: CGS - Jurisdiction C  
Attn: ADMC  
PO Box 20010  
Nashville, TN 37202  
Fax: 1.615.782.4647 |
| Prior Authorization                                    | Address: CGS Medical Review - Prior Authorization  
PO Box 24890  
Nashville, TN 37202  
Fax: 1.615.664.5960 |
| Supplier Enrollment                                    | Address: National Supplier Clearinghouse  
Palmetto GBA * AG-495  
PO Box 100142  
Columbia, SC 29202-3142  
Phone: 1.866.238.9652 |