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1. General Information

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.8

Before submitting a claim to the DME MAC, you must have on file a dispensing order, the written order, the Certificate of Medical Necessity (CMN) (if applicable), the DME MAC Information Form (DIF) (if applicable), information from the treating physician concerning the patient's diagnosis¹, and any information required for the use of specific modifiers or attestation statements as defined in certain Local Coverage Determinations (LCDs) (see Chapter 9 of this manual for information about LCDs). You should also obtain as much documentation from the patient's medical record as you determine you need to assure that coverage criterion for an item has been met. If the information in the beneficiary's medical record does not adequately support the medical necessity for the item, you are liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

Please see Chapter 4 of this manual for information regarding CMNs and DIFs.

Documentation must be maintained in your files for seven years.

2. Definition of Physician

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §40.4

Physician means any of the following entities legally authorized to practice by a state in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations posed by the State on the scope of practice.

- Doctor of medicine;
- Doctor of osteopathy (including osteopathic practitioner) - must be licensed to practice medicine and surgery;
- Doctor of dental surgery or dental medicine;

¹ ICD-9 codes are required on all claims

- Chiropractor (see below);
- Doctor of podiatry (see below) or surgical chiropody, and;
- Doctor of optometry.

The following practitioners may document the medical necessity of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items, including completing orders and Certificates of Medical Necessity (CMNs), in place of a physician provided that they meet the practitioner requirements defined in Chapter 15 of the Benefit Policy Manual (Publication 100-02), the services performed are within their scope of practice as defined by their state, and they are treating the beneficiary for the condition for which the item is needed.

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist

The term physician does not include such practitioners as Christian Science practitioner or naturopath. There is no Medicare benefit for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items ordered by these entities.

Medicare coverage for all items and services furnished or ordered by chiropractors, with the exception of treatment by means of manual manipulation of the spine to correct a subluxation, is statutorily excluded. Therefore, all DMEPOS items ordered by chiropractors are denied.

Medicare coverage for all items and services furnished or ordered by podiatrists is limited by state statutes governing the scope of practice for podiatry. You should be familiar with the limitations imposed by the statutes of the state(s) in which you operate and dispense DMEPOS items. Claims submitted to the DME MAC, when furnished or ordered by podiatrists practicing outside the limits of their licensures, will be denied as statutorily non-covered. Podiatrists are excluded by statute from ordering a power operated vehicle (POV) or power wheelchair.

3. Orders

VERBAL AND PRELIMINARY WRITTEN ORDERS

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.2.2

You must have an order from the treating physician before dispensing a DMEPOS item to a beneficiary. Except for items requiring a written order prior to delivery, the dispensing order may be a written, fax, or verbal order. The dispensing order must include:

- A description of the item;
- The beneficiary's name;
- The name of the physician; and
- The date of the order.

You must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to the DME MAC or Zone Program Integrity Contractor (ZPIC)

upon request. Except for items requiring a detailed written order prior to delivery (see below), if you do not have an order from the treating physician before dispensing an item, it will be denied as not medically necessary. Please see Chapter 14 of this manual for information regarding the ZPIC.

DETAILED WRITTEN ORDERS

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.4.1.B & Chapter 5, §5.2.3

Detailed written orders are required for all transactions involving DMEPOS; the order must include the above information required for verbal and preliminary written orders. The order must be signed and dated (handwritten or electronic only—stamped signatures and dates are not acceptable) by the physician. Detailed written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document (Reference: CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, section 3.4.1.1.B).

All orders must clearly specify the start date of the order.

For items that are dispensed based on a verbal order or preliminary written order, you must obtain a detailed written order that meets the requirements of this section.

If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need (for example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month or until the ulcer heals).

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.

If the order is for a rented item or if the coverage criteria in a policy specify length of need, the order must include the length of need.

If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable).

Someone other than the physician may complete the detailed description of the item; however, the treating physician must review the detailed description and personally sign and date (handwritten or electronic only—stamped signatures and dates signature and date stamps are not acceptable) the order to indicate agreement.

You must have a detailed written order prior to submitting a claim. If you do not have a faxed, photocopied, electronic, or pen and ink signed detailed written order in your records before you submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category and is therefore not appealable by the supplier (See CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 29 for more information on appeals). For all other items, if you do not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary.

For items that require a Certificate of Medical Necessity (CMN), the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed. See Chapter 4 of this manual for information regarding CMNs.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, and limitations) is NOT in itself considered to be part of the order although it may be put on the same document as the order.

In other sections of this manual, the term “order” or “written order” means “detailed written order” unless otherwise specified.

WRITTEN ORDER PRIOR TO DELIVERY

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.2.3.1

Certain items require a detailed written order prior to delivery (see list of HCPCS below). For these items, you must have received a written order that has been both signed and dated by the treating physician and meets the requirements for orders before dispensing the item. If you bill for an item without a written order in situations when you are required to have a written order prior to delivery, the item will be denied as statutorily non-covered.

DME MACs and ZPICs may identify other items for which they will require a written order prior to delivery.

HCPCS Codes Subject to Written Order Prior to Delivery**Decubitus Care**

- A4640 Replacement pad for use with medically necessary alternating pressure pad owned by patient
- E0181 Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty
- E0182 Pump for alternating pressure pad, for replacement only
- E0184 Dry pressure mattress
- E0185 Gel or gel-like pressure pad for mattress, standard mattress length and width
- E0186 Air pressure mattress
- E0187 Water pressure mattress
- E0188 Synthetic sheepskin pad
- E0189 Lambs wool sheepskin pad, any size
- E0193 Powered air flotation bed (low air loss therapy)
- E0194 Air-fluidized bed
- E0196 Gel pressure mattress
- E0197 Air pressure pad for mattress, standard mattress length and width
- E0198 Water pressure pad for mattress, standard mattress length and width
- E0199 Dry pressure pad for mattress, standard mattress length and width

- E0277 Powered pressure-reducing air mattress
- E0371 Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
- E0372 Powered air overlay for mattress, standard mattress length and width
- E0373 Non-powered pressure mattress

Seat Lift Mechanism

- E0172 Seat lift mechanism placed over or on top of toilet, any type
- E0627 Seat lift mechanism incorporated into a combination lift-chair mechanism
- E0628 Separate seat lift mechanism for use with patient owned furniture-electric
- E0629 Separate seat lift mechanism for use with patient owned furniture-non-electric

Transcutaneous Electrical Nerve Stimulator (TENS)

- E0720 TENS, two-lead, localized stimulation
- E0730 TENS, four-lead, larger area/multiple nerve stimulation
- E0731 Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)

Power Mobility Devices

- E0983 Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
- E0984 Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
- E0986 Manual wheelchair accessory, push activated power assist, each

All codes for options/accessories for power wheelchairs

- E1230 Power operated vehicle, nonhighway
- E1239 Power wheelchair, pediatric size, NOC
- K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
- K0801 Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds
- K0802 Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds

- K0806 Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
- K0807 Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds
- K0808 Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds
- K0812 Power operated vehicle, not otherwise classified
- K0813 Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
- K0814 Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
- K0815 Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
- K0816 Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0820 Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0821 Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
- K0822 Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0823 Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0824 Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0825 Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 451 to 600 pounds
- K0826 Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0827 Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
- K0828 Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0829 Power wheelchair, group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more
- K0830 Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0831 Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds

- K0835 Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0836 Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
- K0837 Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0838 Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
- K0839 Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0840 Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0841 Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0842 Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds
- K0843 Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0848 Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0849 Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0850 Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0851 Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds
- K0852 Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0853 Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity, 451 to 600 pounds
- K0854 Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0855 Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more
- K0856 Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0857 Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds

- K0858 Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0859 Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
- K0860 Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0861 Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0862 Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0863 Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0864 Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0868 Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0869 Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0870 Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0871 Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0877 Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0878 Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
- K0879 Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0880 Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds
- K0884 Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0885 Power wheelchair, group 4 standard, multiple power option, captain's chair, weight capacity up to and including 300 pounds
- K0886 Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0890 Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds

K0891 Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds

K0898 Power wheelchair, not otherwise classified

K0899 Power mobility device, not coded by SADMERC or does not meet criteria

Wheelchair Seating

E0955 Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each

E0956 Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each

E0957 Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each

E0960 Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware

E0966 Manual wheelchair accessory, headrest extension, each

E0992 Manual wheelchair accessory, solid seat insert

E1028 Wheelchair accessory, manual swing-away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory

E2291 Back, planar, for pediatric size wheelchair including fixed attaching hardware

E2292 Seat, planar, for pediatric size wheelchair including fixed attaching hardware

E2293 Back, contoured, for pediatric size wheelchair including fixed attaching hardware

E2294 Seat, contoured, for pediatric size wheelchair including fixed attaching hardware

E2601 General use wheelchair seat cushion, width less than 22 inches, any depth

E2602 General use wheelchair seat cushion, width 22 inches or greater, any depth

E2603 Skin protection wheelchair seat cushion, width less than 22 inches, any depth

E2604 Skin protection wheelchair seat cushion, width 22 inches or greater, any depth

E2605 Positioning wheelchair seat cushion, width less than 22 inches, any depth

E2606 Positioning wheelchair seat cushion, width 22 inches or greater, any depth

E2607 Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth

E2608 Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth

- E2609 Custom fabricated wheelchair seat cushion, any size
- E2610 Wheelchair seat cushion, powered
- E2611 General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
- E2612 General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
- E2613 Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
- E2614 Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware
- E2615 Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
- E2616 Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware
- E2617 Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
- E2619 Replacement cover for wheelchair seat cushion or back cushion, each
- E2620 Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
- E2621 Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware
- K0734 Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
- K0735 Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
- K0736 Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
- K0737 Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth

Negative Pressure Wound Therapy (NPWT)

- E2402 Negative pressure wound therapy electrical pump, stationary or portable

Requirement of New Orders

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.2.4

A new order is required:

1. When there is a change in the order for the accessory, supply, drug, etc.

2. On a regular basis even if there is no change in the order; only if it is so specified in the documentation section of a particular medical policy.
3. When an item is replaced.
4. When there is a change of supplier.

A new order is required when an item is being replaced because the item is worn or the patient's condition has changed. Your records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in your files and be available to the DME MACs or ZPICs upon request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in claim(s) denial.

A new physician's order is required before replacing lost, stolen, or irreparably damaged items to reaffirm the medical necessity of the item. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement should be submitted with the claim.

Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and CMNs

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.5

A nurse practitioner or clinical nurse specialist may give the dispensing order and sign and date the detailed written order in the following situations (handwritten or electronic only—stamped signatures and dates are not acceptable):

- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing independently of a physician;
- They bill Medicare for other covered services using their own provider number; and
- They are permitted to do all of the above in the State in which the services are rendered.

A nurse practitioner or clinical nurse specialist may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders. See Chapter 4 of the manual for information regarding CMNs.

Physician Assistant Rules Concerning Orders and CMNs

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §§5.3.1 & 5.6

Physician assistants may provide the dispensing order and write, sign, and date the detailed written order (handwritten or electronic only— stamped signatures and dates are not acceptable) if they satisfy all the following requirements:

- They meet the definition of physician assistant found in §1861(aa)(5)(A) of the Act;
- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;
- They have their own NPI; and
- They are permitted to perform services in accordance with State law.

Physician assistants may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders (handwritten or electronic only— stamped signatures and dates are not acceptable).

Supply Replacement/Utilization – Evidence of Medical Necessity

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.9

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating physician must specify on the prescription, or on the CMN, the type of supplies needed and the frequency with which they must be replaced, used, or consumed. DME MACs and ZPICs evaluate supply utilization information as part of the medical necessity determination for DMEPOS. "PRN" or "as needed" utilization estimates for supply replacement, use, or consumption are not acceptable.

Absent a state law to the contrary or a supply utilization problem, the prescription or physician's certification submitted for the DMEPOS may also serve as medical evidence for supply replacement claims; however, when a prescription for DMEPOS is renewed or revised, supply utilization information must be specified or updated by the physician on the CMN. DME MACs and ZPICs assess the continuing medical necessity.

The DME MACs or ZPICs have procedures in place to monitor utilization of replacement supplies. Suppliers must submit updated medical information of the patient's condition resulting in changes of the equipment device, or supply utilization. Claims submitted with unexpected increases in supply utilization without supportive documentation will be denied. You must provide this information with the claim where indicated in published policy or make it available to the DME MACs or ZPICs on request.

If necessary or appropriate for a medical necessity determination, the DME MAC or ZPIC must ask you to obtain documentation from the treating physician, establishing the severity of the patient's condition, the immediate and long term need for the equipment, and the therapeutic benefits the patient is expected to realize from its use. A claim of therapeutic effectiveness or benefit based on speculation or theory alone cannot be accepted. When restoration of function is cited as a reason for use of DMEPOS, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in which the equipment or device will restore or improve the bodily function should be explained by the treating physician.

If the DME MAC or ZPIC is unsuccessful in obtaining medical information from a supplier for non-assigned claims, it gives the beneficiary the opportunity to obtain the desired information from the supplier. If, after obtaining the requested information, a question of medical necessity remains, the DME MAC or ZPIC medical staff must resolve the issue.

Acceptability of Faxed Orders and Facsimile or Electronic CMNs or DIFs

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.3

When reviewing claims and orders or auditing CMNs or DIFs for DMEPOS, DME MACs and ZPICs may encounter faxed, copied, or electronic orders, CMNs, and DIFs in supplier files. The DME MACs and ZPICs will accept these documents as fulfilling the documentation requirements.

The DME MACs and ZPICs retain the authority to request additional documentation to support the claim. If a DME MAC finds indications of potential fraud or misrepresentation of these documents or the claims submitted, they will refer the matter to the ZPIC for development. See Chapter 4 of this manual for information regarding CMNs.

4. Certificates of Medical Necessity

Information about Certificates of Medical Necessity (CMNs) may be found in Chapter 4 of this manual.

5. Documentation in the Patient's Medical Record

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.7

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record; however, neither a physician's order, nor a CMN nor a DIF nor a supplier-prepared statement nor physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier-prepared statement or physician attestation (if applicable).

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists.

The documentation in the patient's medical record does not need to be routinely sent to you or to the DME MACs or ZPICs; however, the DME MAC or ZPIC may request this information in selected cases. If the DME MAC or ZPIC does not receive the information when requested, or if the information in the patient's medical record does not adequately support the medical necessity for the item, then for assigned claims you are liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained. See the Advanced Beneficiary Notice section below for information about ABNs.

6. Beneficiary Authorization

You may only receive Medicare payment if the beneficiary assigns his or her Medicare benefits to you. Regulations authorize Medicare to pay for claims submitted by a supplier only if the beneficiary or the person authorized to request payment on the beneficiary's behalf assigns the claims to the supplier and the supplier accepts assignment. For all claims submitted on or after January 1, 2005, payment shall be made to physicians and suppliers even without a beneficiary-signed assignment of benefits (AOB) form when the service can only be paid on an assignment related basis. This includes any mandatory assignment situations and participating physician or supplier situations. When you accept assignment, you must accept Medicare's determination of the approved amount as the full fee for the service(s) rendered. For more information about beneficiary authorization, see the Chapter 6 of this manual.

7. Proof of Delivery

SUPPLIER PROOF OF DELIVERY DOCUMENTATION REQUIREMENTS

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 4, §§4.26 – 4.26.2 & Chapter 5, §5.8o

You are required to maintain proof of delivery documentation in your files. Documentation must be maintained in your files for seven years.

Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12) and in Chapter 2 of this manual. Proof of delivery documentation must be available to the DME MAC and ZPIC on request. If you consistently do not provide documentation to support your services, you may be referred to the OIG for investigation and/or imposition of sanctions.

PROOF OF DELIVERY AND DELIVERY METHODS

For the purpose of the delivery methods noted below, **designee** is defined as:

“A person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary.”

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip that you obtain (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, you (or the shipping service) should note the name of the designee on the delivery slip.

You may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed and dated delivery slip. It is recommended that the delivery slip include:

- The beneficiary's name;
- The quantity delivered,
- A detailed narrative description of the item,
- The brand name (manufacturer),
- The model name or number (if applicable), and
- The serial number (if available).

NOTE: The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee and must be the Date of Service on the claim.

If you utilize a shipping service or mail order, an example of proof of delivery would include the service's tracking slip and your own shipping invoice. If possible, your records should also include the delivery service's package identification number for the package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If you utilize a shipping service or mail order, you must use the shipping date as the date of service on the claim.

You may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information concerning the DMEPOS item (i.e., the beneficiary's name, the quantity, detailed description, brand name, and serial number) as well as the

required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

For DMEPOS products that are supplied as refills to the original order, you must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent deliveries of refills, you should deliver the DMEPOS product no sooner than approximately five days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

EXCEPTIONS

Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. You may deliver a DMEPOS item to a beneficiary in a hospital or nursing facility for the purpose of fitting or training the beneficiary in the proper use of the item. This may be done up to two days prior to the beneficiary's anticipated discharge to their home. You must bill the date of service on the claim as the date of discharge and shall use the Place of Service (POS) as 12 (home). The item must be for subsequent use in the beneficiary's home. No billing may be made for the item on those days the beneficiary was receiving training or fitting in the hospital or nursing facility.

Example:

1. A beneficiary is admitted to a hospital stay on June 1.
2. The beneficiary will require the use of a walker upon discharge and must be trained on its use while in the hospital. The walker is provided to the beneficiary in the hospital on June 5.
3. The beneficiary is discharged from the hospital on June 6.

You would then bill the claim to the DME MAC using June 6 as the date of service.

You may not bill for drugs or other DMEPOS items used by the beneficiary prior to the beneficiary's discharge from the hospital or a Medicare Part A nursing facility stay. Billing the DME MAC for surgical dressings, urological supplies, or ostomy supplies that are provided in the hospital or during a Medicare Part A nursing facility stay is not allowed. These items are payable to the facility under Part A of Medicare. This prohibition applies even if the item is worn home by the beneficiary from the hospital or nursing facility. Any attempt by you and/or facility to substitute an item that is payable to you for an item that, under statute, should be provided by the facility, may be considered to be fraudulent. These statements apply to durable medical equipment delivered to a beneficiary in hospitals, skilled nursing facilities (Place of Service = 31), or nursing facilities (Place of Service = 32).

You may deliver a DMEPOS item to a beneficiary's home in anticipation of a discharge from a hospital or nursing facility. You may arrange for actual delivery of the item approximately two days prior to the beneficiary's anticipated discharge to their home. You must bill the date of service on the claim as the date of discharge and use the Place of Service (POS) as 12 (home).

8. Advance Beneficiary Notice (ABN)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §60; Chapter 20, §120; & Chapter 30, §50

An Advance Beneficiary Notice (ABN) is a written notice that a supplier gives to a Medicare beneficiary before providing items and/or services that are expected to be denied by Medicare based on one of the following statutory exclusions:

- Lack of medical necessity
- Prohibited, unsolicited telephone contacts
- No supplier number
- Denial of an Advanced Determination of Medicare Coverage (ADMC) request

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification); however, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered.

On March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the General Use ABN (CMS-R-131-G) and the Lab ABN (CMS-R-131-L) for physician-ordered laboratory tests. Additional information can be found on the Beneficiary Notice Initiative webpage at <http://www.cms.gov/bni/>.

Beginning March 1, 2009, you MUST use the new ABN form CMS-R-131. Prior to March 1, 2009, use of the old form or the new form was permitted. The ABN form can be found online at http://www.cms.gov/BNI/02_ABN.asp.

For an ABN to be acceptable, it must:

- Be on the approved form (beginning March 1, 2009, it must be on the CMS-R-131 form);
- Clearly identify your name, address, and telephone number;
- Clearly identify the beneficiary;
- Clearly identify the particular item and/or service;
- State that you believe Medicare is likely (or certain) to deny payment for the particular item and/or service; and
- Give your reason(s) for your belief that Medicare is likely (or certain) to deny payment for the item and/or service.
- Give a reasonable estimate cost of the noncovered item and/or service
- Be signed and dated by the beneficiary or representative.

The complete ABN completion instructions are available in the CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 30, § 50.6.3.

ABNs apply to assigned and nonassigned claims, as there are financial liability provisions under Medicare law for both claim types:

Limitation of liability (LOL) applies to **assigned** claims for DMEPOS services disallowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or no ADMC. Under LOL, a beneficiary can be held liable for a service denied due to reasons cited on the ABN.

Refund requirements (RR) apply to **assigned and non-assigned** claims for DMEPOS services disallowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or no ADMC. RR state that suppliers must make refunds of any amounts collected if the beneficiary was not properly notified of possible disallowed Medicare claims. The RR provisions require that the beneficiary is notified and agrees to be financially liable.

If you render a service which Medicare considers not medically necessary to a beneficiary, you should notify the beneficiary in writing, **before rendering the service**, that Medicare is likely to deny the claim and that the beneficiary will be responsible for payment. Modifier "GA" should be indicated on the Medicare claim with the appropriate HCPCS code when it is filed. See Chapter 16 of this manual for more information about modifiers.

The following statements are examples of reasons for your belief that Medicare is likely to deny payment:

- Medicare does not usually pay for this many treatments or services
- Medicare usually does not pay for this service
- Medicare does not pay for this because it is a treatment that has yet to be proved effective (experimental)
- Medicare does not pay for this many services within this period of time
- Medicare does not pay for such an extensive treatment

General statements such as "I never know if Medicare will deny payment" are not acceptable.

The beneficiary or his or her representative has the right to appeal a claim decision if there is dissatisfaction with the amount of payment, denial of coverage for services or supplies, or if the original claim was not acted upon within a reasonable time. You have the right to appeal a claim decision when you accept assignment.

As a supplier providing items and services to Medicare beneficiaries, you may appeal an initial determination if:

- You accepted assignment on the claim; or
- You are acting as the duly authorized representative of the beneficiary.

See chapter 13 of this manual for more information about appeals.

When you furnish an upgraded item of DMEPOS and expect Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, you must give an ABN to the beneficiary for signature for holding the beneficiary liable for the additional expense.

9. Miscellaneous Documentation Issues

Repair and Maintenance

CMS Manual System, Pub. 100-2, *Medicare Benefit Policy Manual*, Chapter 15, §§110.2 & 110.4

Under the circumstances specified in the *Medicare Benefit Policy Manual*, payment may be made for repair, maintenance, replacement, and delivery of medically-required DME which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part B of the Medicare program. In addition, payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.

Refer to the individual medical policies for specific coverage and payment provisions.

Delivery and Service Charges

CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 20, §60

Delivery and service are an integral part of the costs of doing business if you are an oxygen and durable medical equipment (DME) supplier. Such costs are ordinarily assumed to have been taken into account (along with all other overhead expenses) in setting the prices that you charge for covered items and services. As such, these costs, whether rented or purchased, have already been accounted for in the calculation of the fee schedules. Therefore, separate delivery and service charges for DMEPOS items will not be allowed except in rare and unusual circumstances when the delivery is outside the normal range of your sphere of operation. For example, a reasonable delivery charge might be allowed if you had to deliver a DMEPOS item to a beneficiary who lived outside your usual customer area and who had no access to another supplier located nearer. You must fully document these "unusual circumstances" on claims filed for delivery charges. These claims will be considered on an individual basis.

Same/Similar Equipment and Advance Beneficiary Notices (ABN)

CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 30

This concerns ANSI Reason Code M3 - "Equipment is the same or similar to equipment already being used." See Chapter 17 of this manual for information about ANSI Reason Codes.

Numerous claims for durable medical equipment are denied because the equipment involved is the same as or similar to equipment already in the possession of the beneficiary. The statutory basis for denial of such claims is medical necessity; therefore, the limitation of liability provision under Section 1879 of the law applies. Backup equipment (standby and precautionary) has no coverage benefit and is considered not medically necessary. See the section *Backup Equipment* below.

Liability is assessed on claims denied based on "same or similar equipment." You are expected to be familiar with DME MAC coverage policies and any additional pertinent information that may have an impact on medical necessity determinations. In order to be protected under the limitation of liability provision, you must provide a proper advance beneficiary notice (ABN) for each item that you believe is likely to be denied as not medically necessary.

There must be a specific, identifiable reason to believe that Medicare may not pay for certain DME items (e.g., "same or similar equipment"). This means that you must obtain all the possible information from beneficiaries in order to determine whether "same or similar equipment" has previously been provided to that beneficiary. You should ask very specific questions when providing items to Medicare patients. When providing equipment to beneficiaries, the following information should always be obtained:

- The beneficiary's correct Health Insurance Claim Number (HICN)
- If the beneficiary has employer insurance or is enrolled in a Medicare Advantage Plan
- If the beneficiary currently has or had rental or ownership of an identical or similar item(s) in the past, you should obtain specific information about:
 - a. When the item(s) was received
 - b. Who supplied the item(s)
 - c. When and why the item(s) was returned
- When the beneficiary received the items and if the items have been returned
- Where the item will be used
- A signed and dated written order from the prescribing physician
- Clinical documentation that demonstrates any change in medical need

You may also access information about any previously submitted same or similar equipment through the CIGNA Government Services Interactive Voice Response System (IVR). This IVR information can be reached by calling 866.238.9650, selecting Option 2, and pressing 3 for CMN status. This option will provide CMN information on file for the procedure code entered and also CMN information on any similar equipment on file for a beneficiary. Facsimile CMN records are established in our system even for equipment which no longer require actual CMNs (such as manual wheelchairs). For more information about the IVR, see Chapter 13 of this manual.

You should make certain that the beneficiary understands that items such as wheelchairs and power-operated vehicles are considered "similar equipment" and that Medicare will not cover both items when they are used simultaneously. You should strongly encourage the beneficiary to inform you if the medical need for the item changes and the beneficiary requires a different piece of equipment that serves a similar purpose. The Medicare program will only allow items that meet the beneficiary's current needs.

For example, if a beneficiary is renting a manual wheelchair and his/her condition worsens to the point that only a different wheelchair, such as a power wheelchair, will meet his/her medical need, coverage will be allowed for the power wheelchair and any subsequent claims for the manual wheelchair will be denied.

If there is no indication that same or similar equipment has been previously obtained, you would not have reason to provide an ABN. If the beneficiary or the beneficiary's authorized representative is unable to respond fully on the issue of "same or similar equipment," the supplier may issue an ABN. In situations where the beneficiary is planning to use a piece of equipment as a backup (e.g., an extra wheelchair to keep in the car), you should ALWAYS obtain a signed ABN. In the event that you appeal a Medicare claim decision, you must submit a copy of the ABN with the appeal request (see Chapter 13 of this manual for information about appeals).

Same or similar rules may not necessarily apply to situations where a new device with additional technological features becomes available. The DME MAC or ZPIC must evaluate whether the new feature(s) meets the beneficiary's medical need and that the need is not met by their current equipment. If the new feature or device meets a current medical need that is not met by the current equipment because the appropriate technology was not available at the time the beneficiary obtained the item, even if there has been no change in the beneficiary's condition, the five-year

useful lifetime rules do not apply and the new item may be provided. However, if the new item is meeting the same medical need as the old item but in a more efficient manner or is more convenient, AND there is no change in the beneficiary's condition, Medicare will NOT reimburse for the new item.

The following examples illustrate these instructions:

1. The beneficiary receives a power wheelchair *without* power tilt/recline. Subsequently it is determined that the beneficiary needs a tilt/recline AND he/she has needed it since the provision of the initial power wheelchair. Often, the old wheelchair base will not accommodate the new tilt/recline system; therefore, in addition to the tilt/recline, the supplier asks for a wheelchair base to be reimbursed. In this case one of the following options would apply:
 - A. If the old wheelchair is rented, an additional amount for the tilt/recline would be allowed but not a new rental period for the new wheelchair base.
 - B. If the old wheelchair was purchased, only reimbursement of the tilt/recline would be allowed and not the purchase of a new wheelchair base.
2. Code E2101 represents a code for a home glucose monitor that integrates the lancing and application of blood to the glucose testing strip in one machine. The Glucose Monitors Local Coverage Determination (LCD) allows payment for these devices for beneficiaries with manual dexterity problems. If a beneficiary had manual dexterity problems at the time that an E0607 monitor was purchased and the technology of monitors coded E2101 was not available at the time the beneficiary obtained the E0607, they would be allowed to purchase the E2101 to address their medical need for a monitor that accommodates their dexterity problem. No "same or similar" denial would apply. The E0607 did not accommodate their medical need and while their medical need did not change, technology changed such that their medical need could now be met by the new technology.

These rules apply when the new device with advanced features is classified by the same HCPCS code as the older device or when described by a different HCPCS code. If, however, the new device is described by a different code, the beneficiary must also meet the coverage criteria of the new item.

Pick-up Slips

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.12

Medicare regulation specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month.

For purposes of this section, a pick-up slip is written confirmation, provided by a supplier, that the supplier has removed an item of DME from the beneficiary's home. When making determinations, DME MACs or ZPICs must ascertain not only whether equipment is present in the home, but must determine which equipment is actually being used by the patient. Therefore, it is inappropriate to determine, solely based on lack of a pick up slip that a piece of equipment may still be in use. Likewise, it is inappropriate for DME MACs or ZPICs to deny claims solely based on lack of a pick up slip. DME MACs or ZPICs should develop these claims to determine which piece of equipment is medically necessary.

Backup Equipment

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for the beneficiary but is provided for precautionary reasons to deal with an emergency in which the primary piece of equipment malfunctions. **Medicare does not pay separately or make an additional payment for backup equipment.**

When a determination is made that if a particular piece of equipment breaks down or malfunctions it will result in immediate life-threatening consequences for the beneficiary, Medicare will place that item in the frequent and substantial servicing payment category (see Chapter 5 of this manual for information about payment categories). For items in this payment category, Medicare will reimburse for monthly rental payments for as long as the equipment is medically necessary. Consequently, you are responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment.

The expectation is that an acceptable plan would involve input from the beneficiary and the treating physician and would take into account the severity of the beneficiary's condition and time restraints in providing emergency support. This means that you are responsible for ensuring that the beneficiary's medical needs for the use of this equipment will be met on a continuous and ongoing basis and that there is a plan to deal with any interruptions in the use of the equipment that would be life-threatening to the beneficiary. The plan may be as simple as furnishing backup equipment; however, Medicare will not pay separately and/or make any additional payment for the backup equipment. The payment for the primary piece of equipment would include the cost of that piece of equipment and the frequent and substantial servicing plan that you must provide to ensure that the beneficiary always has a piece of equipment that is in working order. If the backup equipment is billed, it will be denied as not being reasonable and necessary.

Backup equipment must be distinguished from multiple medically necessary items that are defined as identical or similar devices, each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the beneficiary's medical needs.

Examples (not all-inclusive) of situations in which multiple items may be covered are:

1. A beneficiary requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of device (e.g., positive pressure respiratory assist device with a nasal mask) during the rest of the day.
2. A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.
3. A beneficiary requires one type of infusion pump for a particular drug (e.g., a pump with patient control features for parenteral morphine) and needs a different type of pump for another drug (e.g., continuous infusion chemotherapy).

Examples (not all-inclusive) of situations in which a second or other multiple piece of equipment would be considered a backup and therefore would not be covered are:

1. A ventilator-dependent beneficiary is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.
2. The drug epoprostenol (Flolan®) is administered using an ambulatory infusion pump, and a second infusion pump is provided and billed as a precaution in case of malfunction of the primary pump. Because interruption of a continuous infusion of this drug results in immediate life-threatening consequences, a unique code, K0455, has been established for an infusion pump used to administer this drug, and the code is in the frequent and substantial servicing payment category.

Miscellaneous HCPCS Codes

Unusual services and items are generally reported to the contractor with miscellaneous HCPCS codes. These miscellaneous HCPCS codes do not have established fee schedule reimbursement rates. Each item/service is processed based on individual consideration. In these situations you must furnish documentation describing the service or item, manufacturer name, product name and number, and the suggested retail price. If it is a customized option/accessory, the statement must clearly describe what was customized. When necessary, consultants' advice will be obtained.

If the description, manufacturer name, product name, product number and suggested retail price are not provided with the claim, the claim may be developed for additional information. If there is no response to the request for additional information, the claims will be denied for missing information and you will be responsible for resubmitting the claims with the appropriate information.

Claims for option/accessory codes as a replacement must be submitted with the make and model name of the equipment base the item is being added to, the date of the purchase of the equipment base, and documentation of the medical necessity for the item.

The definitions of HCPCS codes are meant to be broadly inclusive. All related components are included in the codes and should generally not be billed separately unless specifically allowed in the definition or description of a HCPCS code. If you choose to bill separately for an included component, HCPCS code A9900 (miscellaneous DME supply, accessory and/or service component of another HCPCS code) must be used and will be denied as not separately payable. If an included component is billed with a miscellaneous HCPCS code, then that claim line will be rejected as incorrect coding.

10. Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.9.2

As the result of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living **within the home**. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home.

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person physician-patient encounter (*the in-person visit and medical examination together are often referred to as the "face-to-face" exam*).

2. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. The evaluation must clearly distinguish the patient's mobility needs within the home from their needs outside the home.

Documentation can also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to support the severity of the patient's ambulatory problems.

3. The prescription must only be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
4. The prescription and medical records documenting the in-person visit and examination report must be sent to the equipment supplier within 45 days of the completion of the examination. For those instances of a recently hospitalized beneficiary, you must receive the written order within 45 days after the date of discharge from the hospital.

You must document the receipt date with a date stamp or equivalent.

The written order for the PMD must be in writing and signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist) who performed the in-person examination. The in-person examination requirement does not apply when only accessories for power mobility devices are being ordered.

The written order/prescription must contain the following seven elements:

- Beneficiary's name
- Date of completion of the in-person examination
- Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
- Description of the item that is ordered. This may be general—e.g., "power operated vehicle", "power wheelchair", or "power mobility device"—or may be more specific.
- Length of need
- Physician's signature
- Date of physician signature

Once you have determined the specific power mobility device that is appropriate for the patient based on the physician's order, you must prepare a written document (termed a detailed product description) that lists the wheelchair base and all options and accessories that will be separately billed. For the wheelchair base and each option/accessory, you must enter all of the following:

- HCPCS code
- Narrative description of the HCPCS code
- Manufacturer name and model name/number

- Supplier's charge
- Medicare fee schedule allowance

If there is no fee schedule allowance, must enter "not applicable". The physician must sign and date this detailed product description and you must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document receipt date. The detailed product description must be available on request.HCPCS code.

You should refer to the individual medical policies for specific coverage and payment provisions.

As defined in the CMS Manual System (Pub. 100-8, Medicare Program Integrity Manual, Chapter 3), if data analysis indicates potentially aberrant billing, contractors shall continue to follow the general guidance for performing medical review on claims.

For more information regarding mobility devices, please consult the appropriate Local Coverage Determination (LCD).

11. Comprehensive Error Rate Testing (CERT)

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 12

The Centers for Medicare & Medicaid Services (CMS) developed the Comprehensive Error Rate Testing (CERT) program to produce national, contractor-specific, and service-specific claim error rates. The program has independent reviewers who periodically review representative random samples of Medicare claims. The independent reviewers medically review claims that are paid and claims that are denied to ensure the claim decision was appropriate. CERT was implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Each month the CERT contractor selects a random sample of claims processed by each Medicare contractor, including the DME MACs. They then request medical records, Certificates of Medical Necessity, and supporting documentation from the provider of the service to verify services billed were delivered and medically necessary and that claims were processed appropriately. If you are contacted for a CERT review, you will be provided with the details regarding the needed information and how to submit it.

When no medical records or supporting documentation are received, a denial decision is made which ultimately results in a request for refund from the provider if the claim had been paid originally. These claims may be appealed through normal channels at the DME MAC (see Chapter 13 of this manual for information about appeals).

When records and/or documentation are received, the CERT contractor's medical review staff (includes nurses, physicians, and other qualified healthcare practitioners) then perform a complete review of the claims. If documentation fails to support the item(s) billed, an error is called and a refund will be requested. Documentation that supports the medical need will result in no further action needed by the provider.

Additional information about CERT may be found on the CMS website at <http://www.cms.gov/cert/> or through our website, www.cignagovernmentservices.com/jc.