Medicare Claims Processing Manual

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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01 - Foreword

(Rev.)

42 CFR 400.202, PIM Chapters 6 and 10

This chapter provides general instructions on billing and claims processing for durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), and supplies. Coverage requirements are in the Medicare Benefit Policy Manual and the National Coverage Determinations Manual.

These instructions are applicable to services billed to the carrier, DMERC, intermediary, and RHHI unless otherwise noted.

DME, prosthetic/orthotic devices (except customized devices in a SNF), supplies and oxygen used during a Part A covered stay for hospital and skilled nursing facility (SNF) inpatients are included in the inpatient prospective payment system (PPS) and are not separately billable.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

  Of these provider types only hospitals, CAHs, SNFs, and HHAs would be able to bill for DMEPOS; and for hospitals, CAHs, and SNFs usually only for outpatients. Any exceptions to this rule are discussed in this chapter.

- **Supplier** means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

  A DMEPOS supplier must meet certain requirements and enroll as described in Chapter 10 of the Program Integrity Manual. A provider that enrolls as a supplier is considered a supplier for DMEPOS billing. However, separate payment remains restricted to those items that are not considered included in a PPS rate.

Unless specified otherwise the instructions in this chapter apply to both providers an suppliers, and to the contractors that process their claims.

10 - Where to Bill DMEPOS and PEN Items and Services

(Rev.)

A3-3113, B3-2100, HHA-220, HHA-461 (partial), HO-228 (partial), HO-235, SNF-264, Region C DMERC Manual (as reference), PM B-02-041

SNFs, CORFs, OPTs, and hospitals bill the intermediary for prosthetic/orthotic devices, supplies, and covered outpatient DME and oxygen (refer to §80.2 and §40). HHAs may bill DME to the RHHI, or may meet the requirements of a DME supplier and bill the DMERC. This is the HHA's decision. Intermediaries other than RHHIs will receive claims only for the class "Prosthetic and Orthotic Devices."

Unless billing to the intermediary is required as outlined in the preceding paragraph, claims for implanted DME, implanted prosthetic devices, replacement parts, accessories and supplies for the implanted DME must be billed to the local carriers and not the DMERC. The Healthcare Common Procedure Coding System (HCPCS) codes that describe these categories of service are updated annually in late spring, and are published in the DMERC manual distributed by the DMERCs.

All other DMEPOS items are billed to the DMERC.

Additional instructions and examples for billing equipment and supplies to DMERCs are included in the Durable Medical Equipment Regional Carrier (DMERC) Manuals available from the individual DMERC Carrier Web sites. These are:

Region A, Healthnow New York, Inc: www.umd.nycpic.com

Region B, AdminaStar Federal, Inc.: www.astar-federal.com

Region C, Palmetto Government Benefits Administrators: www.palmettogba.com

Region D, CIGNA: www.cignamedicare.com

For DMERC jurisdictions, see http://www.cms.hhs.gov/contacts/incardir.htm. The DMERC manuals contain two tables that describe:

- Who to bill for which HCPCS code (i.e., Durable Medical Equipment Regional Carrier (DMERC) or local contractor); and,
- Which DMERC to bill depending on the location of the beneficiary's residence.

Parenteral and enteral nutrition, and related accessories and supplies, are covered under the Medicare program as a prosthetic device. See the Medicare Benefit Policy Manual, Chapter 15, for a description of the policy. All Parenteral and Enteral (PEN) services furnished under Part B are billed to the DMERC. If a provider (see §01) provides PEN items under Part B it must qualify for and receive a supplier number and bill as a supplier. Note that some PEN items furnished to hospital and SNF inpatients are

included in the Part A PPS rate and are not separately billable. (If a service is paid under Part A it may not also be paid under Part B.)

10.1 - Definitions

(Rev.)

A3-3313.1, B3-2100.1, HHA-220.1, HO-235.1, SNF-264.1

10.1.1 - Durable Medical Equipment (DME)

(Rev.)

DME is covered under Part B as a medical or other health service (§1861(s)(6) of the Social Security Act [the Act]) and is equipment that:

a. Can withstand repeated use;

b. Is primarily and customarily used to serve a medical purpose;

c. Generally is not useful to a person in the absence of an illness or injury; and

d. Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

A SNF normally is not considered a beneficiary's home. However, a SNF can be considered a beneficiary's home for Method II home dialysis purposes. See the Program Integrity Manual, Chapter 5, §1, for guidelines on when a SNF may be considered a home.

For detailed coverage requirements (including definitions and discussion) associated with the following DME terms and circumstances see the Medicare Benefit Policy Manual, Chapter 15, §110:

- "Durability"
- "Medical Equipment"
- "Equipment Presumptively Medical"
- "Equipment Presumptively Nonmedical"
- "Special Exception Items"
- "Necessary and Reasonable"
- "Necessity for the Equipment"

- "Reasonableness of the Equipment"
- "Payment Consistent With What is Necessary and Reasonable"
- "Beneficiary's Home"
- "Establishing the Period of Medical Necessity"
- "Repairs, Maintenance, Replacement and Delivery"
- "Leased Renal Dialysis Equipment"
- "Coverage of Supplies and Accessories"
- "Beneficiary Disposal of Equipment"
- "New Supplier Effective Billing Date"
- "Incurred Expense Date"
- "Partial Months-Monthly Payment"
- "Purchased Equipment Delivered Outside the U.S."

For coverage information on specific situations and items of DME, see the Medicare National Coverage Determinations Manual.

10.1.2 - Prosthetic Devices - Coverage Definition

(Rev.)

Prosthetic devices (other than dental) are covered under Part B as a medical or other health service (§1861(s)(8) of the Act) and are devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Replacements or repairs of such devices are covered when furnished incident to physicians' services or on a physician's orders.

For detailed coverage requirements (including definitions and discussion) associated with the following prosthetic device terms and circumstances see the Medicare Benefit Policy Manual, Chapter 15, §120:

- "Test of Permanence"
- "Prosthetic Lenses"
- "Intraocular Lenses (IOLs)"
- "Supplies, Adjustments, Repairs and Replacements"

For coverage information on specific situations and prosthetic devices, see the Medicare National Coverage Determinations Manual.

10.1.3 – Prosthetics and Orthotics (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) - Coverage Definition

(Rev.)

These appliances are covered under Part B as a medical or other health service (§1861(s)(9) of the Act) when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semi-rigid devices that are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

For detailed coverage requirements (including definitions and discussion) associated with the following terms and circumstances see the Medicare Benefit Policy Manual, Chapter 15, §130:

> "Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes"
>
> "Adjustments and Replacement of Artificial Limbs"

For coverage information on specific situations, braces, trusses, and artificial limbs and eyes, see the National Coverage Determinations Manual.

10.1.4 - Payment Definition Variances

(Rev.)

10.1.4.1 - Prosthetic Devices

(Rev.)

Section 1834(h)(1)(G) of the Act, "Replacement of Prosthetic Devices and Parts," refers to prosthetic devices that are artificial limbs. Section 1861(s) of the Act, which defines "medical and other health services," does not define artificial limbs as "prosthetic devices" (§1861(s)(8)). Rather, artificial limbs are included in the §1861(s)(9) category, "orthotics and prosthetics." When discussing replacement, these instructions will use the term "prosthetic device" as intended by §1834(h)(1)(G), i.e., artificial limbs.

10.1.4.2 - Prosthetic and Orthotic Devices (P&O)

(Rev.)

Except as specifically noted (e.g., IOLs), when discussing payment and other policies, instructions in this chapter will use the terms "prosthetic and orthotic devices" and the abbreviation "P&O" interchangeably to refer to both §1861(s)(8) and (9) services.

10.2 - Coverage Table for DME Claims

(Rev.)

B3-2105

Reimbursement may be made for expenses incurred by a patient for the rental or purchase of durable medical equipment (DME) for use in his/her home provided that all the conditions in column A below have been met. Column B indicates the action contractors will take to establish that the conditions have been met.

A - Conditions	**B - Review Action**
l. Payment may be made for the following:	1. Payment may be made for following:
(a) Items of DME that are medically necessary	(a) The HCPCS file shows coverage status of items. If item is not listed in the HCPCS file**,** the contractor will develop LMRP to determine whether the item is covered.
(b) Separate charges for repair, maintenance and delivery	(b) **Repairs** - only if DME is being purchased or is already owned by patient and repair is necessary to make the equipment serviceable. Medicare pays the least expensive alternative. (See special exception in Chapter 15, §110, of the Medicare Benefit Policy Manual (BPM) for repair of dialysis delivery system.) **NOTE:** See Chapter 15, §110 of the BPM for handling claims suggesting deliberate or malicious damage or destruction. **Maintenance -** only if the equipment is being purchased, or is already owned by the patient, and if the maintenance is extensive amounting to repairs, i.e., requiring the services of skilled technicians. (Contractors deny claims for **routine** maintenance and periodic servicing, e.g., testing, cleaning, checking, oiling, etc.) (See special exception in Chapter 15, §110, of the BPM for maintenance of dialysis delivery system.) **Delivery -** of rented or purchased

A - Conditions	B - Review Action
	equipment is covered, but the related payment is included in the fee schedule for the item. Additional payment may be made at the discretion of the contractor in special circumstances (see Chapter 15, §110, of BPM)
(c) Separate charges for disposable supplies, e.g., oxygen, if essential to the effective use of medically necessary durable medical equipment. Separate charges for replacement of essential accessories such as hoses, tubes, mouthpieces, etc., only if the beneficiary owns or is purchasing durable medical equipment (BPM, Chapter 15, §110). (Medications used in connection with durable medical equipment are covered under certain conditions - see BPM §110.5)	(c) Claim must indicate that: • The patient has the DME for which the supply is intended; • The DME continues to be medically necessary; and • The items are readily identifiable as the type customarily used with such equipment. **NOTE:** If the quantity of accessories and/or supplies included in a claim seems excessive or if claims for such items are received from the same claimant with undue frequency, see Chapter 5, §3, of the Medicare Program Integrity Manual (PIM)
2. DME must be for use in patient's residence other than a health care institution. (BPM §110.3 & PIM, Chapter 5, §1)	2. Payment cannot be made for equipment for use in an institution classified as: a. A participating hospital, b. An emergency hospital, c. Meets §1861(e)(1) of the Act, d. A participating SNF or e. Meets §1819(a)(1) of the Act. Except for a distinct part of a SNF, if one of these institutions has a distinct part that does not meet 1819(a)(1), the patient may be considered in his/her residence if he/she was physically located in such distinct part during the use period.

A - Conditions	B - Review Action
	DMEPOS (DME, P&O, and supplies) items provided to hospice patients are generally included in the payment for hospice services. Items of DMEPOS are covered by Medicare and paid in addition to the hospice payment only when those items or supplies are provided to the patient for treatment of a condition or illness not related to the patient's terminal illness.
3. Physician's prescription required.	A supplier must maintain and, upon request, make available to the contractor, the detailed written order (or, when required, the Certificate of Medical Necessity (CMN)) from the treating physician. See PIM, Chapter 5, §§1-3.

10.3 - Beneficiaries Previously Enrolled in Managed Care Who Return to Traditional Fee for Service (FFS)

(Rev.)

B3-9051

When a beneficiary who was previously enrolled in a Medicare HMO/Managed Care program returns to traditional FFS, he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. When a beneficiary returns to FFS, it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may continue to receive such items and services only if they would be entitled to them under Medicare FFS coverage criteria and documentation requirements.

For example, if a beneficiary received a manual wheelchair under a HMO/Managed Care plan, he or she would need to meet Medicare coverage criteria and documentation requirements for manual wheelchairs. He or she would have to obtain a Certificate of Medical Necessity (CMN), and would begin an entirely new rental period, just as a beneficiary enrolled in FFS, to obtain a manual wheelchair for the first time.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. For purposes of this instruction, CMS has interpreted an end to medical necessity to include enrollment in an HMO for 60 or more days.

Another partial exception to this rule involves home oxygen claims. If a beneficiary has been receiving oxygen while under a Medicare HMO, the supplier must obtain an initial CMN and submit it to the DMERC at the time that FFS coverage begins. However, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the Initial Certification date on the CMN, but the test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

Another partial exception to this rule involves home oxygen claims. If a beneficiary has been receiving oxygen while under a Medicare HMO, the supplier must obtain an initial CMN and submit it to the DMERC at the time that FFS coverage begins. However, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the Initial Certification date on the CMN, but the test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or Managed Care plan no longer participates in the Medicare + Choice (HMO) program.

20 - Calculation and Update of Payment Rates

(Rev.)

B3-5017, PM B-01-54, 2002 PEN Fee Schedule

Section1834 of the Act requires the use of fee schedules under Medicare Part B for reimbursement of durable medical equipment (DME) and for prosthetic and orthotic devices, beginning January 1 1989. Payment is limited to the lower of the actual charge for the equipment or the fee established.

Beginning with fee schedule year 1991, CMS calculates the updates for the fee schedules and national limitation amounts and provides the contractors with the revised payment amounts. CMS calculates most fee schedule amounts and provides them to the carriers, DMERCs, intermediaries and RHHIs. However, for some services CMS asks carriers to calculate local fee amounts and to provide them to CMS to include in calculation of national amounts. These vary from update to update, and CMS issues special related instructions to carriers when appropriate.

Parenteral and enteral nutrition services paid on and after January 1, 2002 are paid on a fee schedule. This fee schedule also is furnished by CMS. Prior to 2002, payment amounts for PEN were determined under reasonable charge rules, including the application of the lowest charge level (LCL) restrictions.

The CMS furnishes fee schedule updates (DMEPOS, PEN, etc.) at least 30 days prior to the scheduled implementation. Fiscal intermediaries use the fee schedules to pay for covered items, within their claims processing jurisdictions, supplied by hospitals, home health agencies, and other providers. Fiscal intermediaries consult with DMERCs and where appropriate with carriers on filling gaps in fee schedules.

CMS furnishes the fee amounts annually, or as updated if special updates should occur during the year, to carriers and intermediaries, including DMERCs and RHHIs, and to other interested parties (including the Statistical Analysis DMERC (SADMERC), Railroad Retirement Board (RRB), Indian Health Service, and United Mine Workers).

20.1 - Update Frequency

(Rev.)

The DMEPOS fee schedule is updated annually to apply update factors and quarterly to include new codes and correct errors.

20.2 - Locality

(Rev.)

B3-5017.1

For services furnished on or after January 1, 1987, the U.S. is considered one locality.

The U.S. constitutes a "medical service area comparable to the concept of trade areas," for the furnishing of enteral and parenteral therapies. The therapies, nutrients and associated supplies are only available from nationally recognized manufacturers and a review of their published price lists displayed no variation based upon individual State or other localities.

20.3 - Elimination of "Kit" Codes and Pricing of Replacement Codes

(Rev.)

PM B-01-56

Prior to 2002, most suppliers billed for dialysis supplies using codes describing "kits" of supplies. The use of kit codes allowed suppliers to bill for supply items without separately identifying the supplies that are being furnished to the patient. Effective January 1, 2002, these kit codes were deleted and suppliers are required to bill for dialysis supplies using HCPCS codes for individual dialysis supplies.

20.4 - Contents of Fee Schedule File

(Rev.)

PM A-02-090

The fee schedule file provided by CMS contains HCPCS codes and related prices subject to the DMEPOS fee schedules, including application of any update factors and any changes to the national limited payment amounts. The file does not contain fees for drugs that are necessary for the effective use of DME. It also does not include fees for items for which fee schedule amounts are not established. See Chapter 23 of the Medicare Claims Processing Manual for a description of pricing for these. CMS releases via program issuance, the gap-filled amounts and the annual update factors for the various DMEPOS payment classes:

- IN = Inexpensive/routinely purchased...DME;
- FS = Frequency Service...DME;
- CR = Capped Rental... DME;
- OX = Oxygen and Oxygen Equipment... OXY;
- OS = Ostomy, Tracheostomy and Urologicals...P/O;
- S/D = Surgical Dressings...S/D;
- P/O = Prosthetics and Orthotics...P/O;
- SU = Supplies...DME; and
- TE = TENS...DME,

Regional Home Health Intermediaries (RHHIs) need to retrieve data from all of the above categories. Regular intermediaries only need to retrieve data from categories P/O, S/D and SU. FIs need to retrieve the SU category in order to be able to price supplies on Part B SNF claims.

30 - General Payment Rules

(Rev.)

B3-5102

DMEPOS are categorized into one of the following payment classes:

- Inexpensive or other routinely purchased DME;
- Items requiring frequent and substantial servicing;

- Certain customized items;
- Other prosthetic and orthotic devices;
- Capped rental items; or
- Oxygen and oxygen equipment.

The CMS determines the category that applies to each HCPSC code and issues instructions when changes are appropriate. See §§130 for billing information for each payment class.

DME, including DME furnished under the home health benefit and Part B DME benefit, is paid on the basis of the fee schedule.

Oxygen and oxygen equipment are paid on the basis of a fee schedule.

Any DME or oxygen furnished to inpatients under a Part A covered stay is included in the SNF or hospital PPS rate. When an inpatient in a hospital or SNF is not entitled to Part A inpatient benefits, payment may not be made under Part B for DME or oxygen provided in the hospital or SNF because such facilities do not qualify as a patient's home. The definition of DME in §1861(n) of the Act provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF or hospital. (See BPM Chapter 15 §110). This does not preclude separate billing for DME furnished after discharge.

Payment to providers and suppliers other than Home Health Agencies (HHAs) for supplies that are necessary for the effective use of DME is made on the basis of a fee schedule, except that payment for drugs is made under the drug payment methodology rules (See Chapter 17 of the Medicare Claims Processing Manual for drug payment information.)

Payment for prosthetics and orthotics is made on the basis of a fee schedule whether it is billed to the DMERC or the intermediary.

Payment under Part B for surgical dressings is made on the basis of the fee schedule except:

- Those applied incident to a physician's professional services;
- Those furnished by an HHA; and
- Those applied while a patient is being treated in an outpatient hospital department.

30.1 - Inexpensive or Other Routinely Purchased DME

(Rev.)

For this type of equipment, contractors pay for rentals or lump-sum purchases. However, with the exception of TENS (see 30.1.2), the total payment amount may not exceed the actual charge or the fee schedule amount for purchase.

A - Inexpensive DME

This category is defined as equipment whose purchase price does not exceed $150.

B - Other Routinely Purchased DME

This category is defined as equipment that is acquired at least 75 percent of the time by purchase and includes equipment that is an accessory used in conjunction with a nebulizer, aspirator, or ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices.

30.1.1 - Used Equipment

(Rev.)

For payment purposes, used equipment is considered routinely purchased equipment and is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator).

However, if a beneficiary rented a piece of brand new equipment and subsequently purchased it, the payment amount for the purchase should be high enough so that the total combined rental and purchase amounts at least equal the fee schedule for the purchase of comparable new equipment. The payment amount may be established in this manner only to the extent it does not exceed the actual charge made for the purchase.

EXAMPLES: The fee schedule amounts for an item of DME are ordinarily as follows:

$500 for purchase when the item is new.

$375 for purchase when the item is used.

$50 per month for renting the item.

Situation 1: A beneficiary rented the item when it was brand new for one month and then purchased it for $500. The amount allowed for the purchase is $450 (i.e., $500 minus the $50 allowed for the one month of rental) rather than $375.

Situation 2: A beneficiary rented the item for one month when it was brand new and then purchased it for $400. The amount allowed for the purchase is $400 rather than the $450 that is allowable in situation 1 since the payment amount may not exceed the actual charge for an item.

30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS)

(Rev.)

B3-4107.5, 5102.2.C

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

30.2 - Items Requiring Frequent and Substantial Servicing

(Rev.)

A3-3629

For this type of equipment, contractors pay the fee schedule amounts on a rental basis until medical necessity ends. Contractors cannot pay for purchase of this type of equipment.

30.2.1 - Daily Payment for Continuous Passive Motion (CPM) Devices

(Rev.)

CPM devices (HCPCS code E0935) are classified as items requiring frequent and substantial servicing and are covered as DME as follows (see CIM 60-9):

- Continuous passive motion devices are covered for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3 week period following surgery during which the device is used in the patient's home.

Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period.

30.3 - Certain Customized Items

(Rev.)

A3-3629

Items that require custom fabrication are unsuitable for grouping together for profiling purposes. Therefore there are neither customary and prevailing charges or fee schedules established. Contractors make payment for customized items without appropriate HCPCS codes in a lump-sum based upon individual consideration for each item. For Part A providers, this is a final payment and is not reflected as a Medicare cost in provider cost reports.

30.4 - Other Prosthetic and Orthotic Devices

(Rev.)

A3-3629

For payment purposes, these items consist of all prosthetic and orthotic devices excluding:

- items requiring frequent and substantial servicing;
- customized items;
- parenteral/enteral nutritional supplies and equipment; and
- intraocular lenses.

Other than these exceptions, contractors pay the fee schedule amounts for prosthetic and orthotic devices on a lump-sum purchase basis.

30.5 - Capped Rental Items

(Rev.)

For these items of DME, contractors pay the fee schedule amounts on a monthly rental basis not to exceed a period of continuous use of 15 months. In the tenth month of rental, the beneficiary is given a purchase option (see §30.5.2). If the purchase option is exercised, contractors continue to pay rental fees not to exceed a period of continuous use of 13 months and ownership of the equipment passes to the beneficiary. If the purchase option is not exercised, contractors continue to pay rental fees until the 15 month cap is reached and ownership of the equipment remains with the supplier (see §30.5.4). In the case of electric wheelchairs only, the beneficiary must be given a purchase option at the time the equipment is first provided (see §30.5.3).

30.5.1- Capped Rental Fee Variation by Month of Rental

(Rev.)

For the first three rental months, the capped rental fee schedule is calculated so as to limit the monthly rental to 10 percent of the average of allowed purchase prices on assigned claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5 percent of the average allowed purchase price. After paying the rental fee schedule amount for 15 months, no further payment may be made except for the 6-month maintenance and servicing fee (see §40.2).

30.5.2 - Purchase Option for Capped Rental Items

(Rev.)

Effective May 1, 1991, suppliers must give beneficiaries the option of converting their capped rental equipment to purchased equipment during their 10th continuous rental month. Contractors make no further rental payments after the 11th rental month for capped rental items until the supplier notifies the contractor that it has contacted the beneficiary and furnished him/her with the option of either purchase or continued rental. Information contained in Exhibit 1 may be furnished to beneficiaries by suppliers to help them make a rent/purchase decision. Contractors provide copies of Exhibit 1 to suppliers. Beneficiaries have one month from the date the supplier makes the offer to accept this option. If the beneficiary declines or fails to respond to the purchase option, the contractor continues to make rental payments until the 15-month rental cap is reached.

If the beneficiary accepts the purchase option, the contractor continues making rental payments until a total of 13 continuous rental months have been paid. The contractor will not make any additional rental payments beyond the 13th rental month. On the first day after 13 continuous rental months have been paid, the supplier must transfer title to the equipment to the beneficiary.

30.5.3 - Additional Purchase Option for Electric Wheelchairs

(Rev.)

Effective May 1, 1991, suppliers must give beneficiaries entitled to electric wheelchairs the option of purchasing them at the time the supplier first furnishes the item. Contractors make no rental payment for the first month for electric wheelchairs until the supplier notifies the contractor that it has given the beneficiary the option of either purchasing or renting. Information contained in Exhibit 2 may be furnished to beneficiaries by suppliers to help them make a rent/purchase decision. Contractors provide copies of Exhibit 2 to suppliers. Payment must be on a lump-sum fee schedule purchase basis where the beneficiary chooses the purchase option. If the beneficiary

declines to purchase the electric wheelchair initially, contractors make rental payments in the same manner as any other capped rental item, including the instructions in §30.5.2.

30.5.3.1 - Exhibits

(Rev.)

Exhibit 1 - The Rent/Purchase Option

(Rev.)

You have been renting your (specify the item(s) of equipment) for 10 continuous rental months. Medicare requires (specify name of supplier) to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. After making these additional rental payments, title to the equipment is transferred to you. You have until (specify the date one month from the date the supplier notifies the patient of this option) to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, a total of 15 months. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. After a total of 15 rental months have been paid, title to the equipment remains with the medical equipment supplier; however, the supplier may not charge you any additional rental amounts.

In making your decision to rent or purchase the equipment, you should know that for purchased equipment your supplier may charge you each time your equipment is actually serviced. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year whether or not the equipment is actually serviced.

Exhibit 2 - How Medicare Pays For Electric Wheelchairs

(Rev.)

If you need an electric wheelchair prescribed by your doctor, you may already know that Medicare can help pay for it. Medicare requires (specify name of supplier) to give you the option of either renting or purchasing it. If you decide that purchase is more economical, for example, because you will need the electric wheelchair for a long time, Medicare pays 80 percent of the allowed purchase price in a lump sum amount. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, you

must elect to purchase the electric wheelchair at the time your medical equipment supplier furnishes you the item. If you elect to rent the electric wheelchair, you are again given the option of purchasing it during your 10th rental month.

If you continue to rent the electric wheelchair for 10 months, Medicare requires (specify name of supplier) to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. After these additional rental payments are made, title to the equipment is transferred to you. You have until (specify the date one month from the date the supplier notifies the patient of this option) to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, a total of 15 months. After a total of 15 rental months have been paid, title to the equipment remains with the medical equipment supplier; however, the supplier may not charge you any additional rental amounts.

In making your decision to rent or purchase the equipment, you should know that for purchased equipment, you are responsible for 20 percent of the service charge each time your equipment is actually serviced and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year whether or not the equipment is actually serviced.

30.5.4 - Payments for Capped Rental Items During a Period of Continuous Use

(Rev.)

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 15 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 15 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees (see §40.2) until medical necessity ends or Medicare coverage ceases (e.g., the patient enrolls in an M+C organization). For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. If a supplier makes any additional rental charges, contractors should report questionable situations to the RO of the Inspector General.

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions may last up to 60 consecutive days plus the days remaining in the rental month (this does not mean calendar month, but the 30-day rental period) in which use ceases, regardless of the reason the interruption occurs. Thus, if the interruption is less than 60 consecutive days plus the days remaining in the rental month in which use ceases,

contractors will not begin a new 15-month rental period. Also, when an interruption continues beyond the end of the rental month in which the use ceases, contractors will not make payment for additional rental until use of the item resumes. Contractors will establish a new date of service when use resumes. Unpaid months of interruption do not count toward the 15-month limit.

EXAMPLE

A patient rents an item of equipment for 12 months and is then institutionalized for 45 days. Upon his discharge from the institution, the patient resumes use of the equipment and is considered to be in his 13th month of rental (since the period of institutionalization is not counted) for purposes of calculating the 15-month rental period. Moreover, for the period he was institutionalized, no payment is made for the item of equipment. If the supplier desires, it may pick up the item of equipment during the patient's hospitalization but is required to return the item upon the patient's return home.

If, however, the interruption is greater than 60 consecutive days (plus the days remaining in the rental month in which need ceases) and the supplier submits a new prescription, new medical necessity documentation and a statement describing the reason for the interruption which shows that medical necessity in the prior episode ended, a new 15-month period begins. If the supplier does not submit this documentation, a new 15-month period does not begin.

As a general rule, contractors accept written documentation from suppliers without further development. However, although it is expected that such circumstances are limited in number, they do represent an opportunity for abuse. Therefore, if a pattern of frequent interruptions in excess of 60 days occurs, contractors will institute a thorough medical review of the supplier's claims. Contractors should report questionable situations to the RO of the Inspector General.

If a 15-month rental period has already ended and a greater than 60 consecutive day interruption occurs, contractors will subject any claims purporting to be a new period of medical necessity after the interruption to a thorough medical review to ensure that medical necessity did in fact end after the prior episode.

Additional issues relating to the term "continuous" follow.

Change of Address

If the beneficiary moves during or after the 15-month period, either permanently or temporarily, it does not result in a new rental episode.

Modifications or Substitutions of Equipment

If the beneficiary changes equipment to different but similar equipment, contractors may refer the claim to their medical review unit. If, after thorough review, they conclude that the beneficiary's medical needs have substantially changed and the new equipment is necessary, contractors will begin a new 15-month period. The supplier providing

equipment during the 10th month must also provide the purchase option. Otherwise, they will continue to count against the current 15-month limit and base payment on the least expensive medically appropriate configuration of equipment (if the 15-month period had already expired, they will make no additional rental payments). The principles are described in the Medicare Benefit Policy Manual, Chapter 15.

If the new configuration is a modification of existing equipment through the addition of medically necessary features (e.g., a special purpose back is added to a wheelchair), contractors will continue the 15-month rental period for the original equipment and begin a new 15-month rental period for the added equipment.

Change in Suppliers

If the beneficiary changes suppliers during or after the 15-month rental period, this does not result in a new rental episode. For example, if the beneficiary changes suppliers after his 8th rental month, the new supplier is entitled to the monthly rental fee for seven additional months (15 - 8). The supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15-month period (see §40.2).

30.5.5 - Payment for Power-Operated Vehicles that May Be Appropriately Used as Wheelchair

(Rev.)

B3-5107.1

The allowed payment amount for a power-operated vehicle that may be appropriately used as wheelchair, including all medically necessary accessories, is the lowest of the:

- Actual charge for the power-operated vehicle, or
- Fee schedule amount for the power-operated vehicle.

30.6 - Oxygen and Oxygen Equipment

(Rev.)

For oxygen and oxygen equipment, contractors pay a monthly fee schedule amount per beneficiary. Unless otherwise noted below, the fee covers equipment, contents and supplies. Payment is not made for purchases of this type of equipment.

When an inpatient is not entitled to Part A, payment may not be made under Part B for DME or oxygen provided in a hospital or SNF. (See Benefit Policy Manual Chapter 15 §110) Also, for outpatients using equipment or receiving oxygen in the hospital or SNF and not taking the equipment or oxygen system home, the fee schedule does not apply.

There are a number of billing considerations for oxygen claims. The chart in §130.6 indicates what amounts are payable under which situations.

30.6.1 - Adjustments to Monthly Oxygen Fee

(Rev.)

If the prescribed amount of oxygen is less than 1 liter per minute, the fee schedule amount for stationary oxygen rental is reduced by 50 percent.

The fee schedule amount for stationary oxygen equipment is increased under the following conditions. If both conditions apply, contractors use the higher of either of the following add-ons. Contractors may not pay both add-ons:

a. 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, contractors use the prescribed amount for stationary systems and for patients at rest. If the prescribed liter flow is different for day and night use, contractors use the average of the two rates.

b. 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.

30.6.2 - Purchased Oxygen Equipment

(Rev.)

Contractors may not pay for oxygen equipment that is purchased on or after June 1, 1989.

30.6.3 - Contents Only Fee

(Rev.)

Where the beneficiary owns stationary liquid or gaseous oxygen equipment, the contractor pays the monthly oxygen contents fee. For owned oxygen concentrators, however, contractors do not pay a contents fee.

Where the beneficiary either owns a concentrator or does not own or rent a stationary gaseous or liquid oxygen system and has either rented or purchased a portable system, contractors pay the portable oxygen contents fee.

30.7 - Payment for Parenteral and Enteral Nutrition (PEN) Items and Services

(Rev.)

Payment for PEN items and services is made in a lump sum for nutrients and supplies that are purchased and on a monthly basis for equipment that is rented.

30.7.1 - Payment for Parenteral and Enteral Pumps

(Rev.)

B3-5017; PM B-01-54

Effective April 1, 1990, claims for rental of parenteral and enteral pumps are limited to payments for a total of 15 months during a period of medical need. Payment policies for these pumps generally follow the rules for capped rental items.

A period of medical need ends when enteral or parenteral nutrients are not medically necessary for 2 consecutive months.

Contractors do not allow additional rental payments once the 15-month limit is reached or pump is purchased unless the attending physician changes the prescription between parenteral and enteral nutrients.

Contractors do not begin a new 15-month rental period when a patient changes suppliers. The new supplier is entitled to the balance remaining on the 15-month rental period.

The supplier that collects the last month of rental (i.e., 15th month) is responsible for ensuring that the patient has a pump for the duration of medical necessity and for maintenance and servicing (M/S) of the pump during the duration of therapy.

A period of voluntary non-billing care and institutional care is not counted toward the 15 months. Calculation is resumed when the voluntary care ends or when the patient is released from institutional care.

An entire month's rent may not be paid when a patient is hospitalized during the month.

The contractor will request documentation to verify a break in medical need of two months or more before approving an additional 15-month rental period.

Contractors notify the supplier of the last rental payment.

The patient has the option of purchasing or renting the pump from the supplier. Contractors must request written authorization from the patient before or after paying for a pump purchase. If the patient decides to purchase the pump once rentals have been paid, the purchase allowance will consist of the used purchase allowance less the amount allowed to date for rentals.

Contractors provide coverage for one pump for parenteral nutrition. Contractors do not allow additional benefits for portable pumps or additional pumps.

30.7.2 - Payment for PEN Supply Kits

(Rev.)

Enteral care kits contain all the necessary supplies for the enteral patient using the syringe, gravity, or pump method of nutrient administration. Parenteral nutrition care kits and their components are considered all-inclusive items necessary to administer therapy during a monthly period.

The DMERC compares the enteral feeding care kits on the claim with the method of administration indicated on the CMN.

The allowance for the amount paid for a gravity-fed care kit is paid when a pump feeding kit is billed in the absence of documentation or unacceptable documentation for a pump.

Payment is denied for additional components included as part of the PEN supply kit.

30.8 - Payment for Home Dialysis Supplies and Equipment

(Rev.)

B3-4272, B3-4272.1 partial, A3-3644, B3-3045.7

There are two methods of payment for home dialysis equipment and supplies: Method I and Method II.

Under Method I, benefits are paid by a Medicare intermediary on the basis of a prospective payment, the composite rate. (See the Medicare Claims Processing Manual, Chapter 8, "Outpatient ESRD (Hospital-Based and Independent RDF Facilities," and Chapter 12, "Physician/Practitioner Billing," for more information on establishing the composite rate).

Under Method II, the DMERC pays for supplies and services other than physician services. Physician services are paid at a monthly capitation rate by the local carrier. See Chapter 8, "Outpatient ESRD (Hospital-Based and Independent RDF Facilities," and Chapter 12, "Physician/Practitioner Billing," for more information on payment under Method II.

30.8.1 - DMERC, Carrier and Intermediary Determination of ESRD Method Selection

(Rev.)

AB-01-61

A - Method Selection and Form CMS-382

The beneficiary must complete Form CMS-382 to choose either Method I or Method II dialysis. Method I dialysis patients receive their home dialysis equipment and supplies from a dialysis facility. Method II patients choose to deal with a home dialysis supplier that is not a dialysis facility. Once a beneficiary has made a method selection choice, the beneficiary or dialysis facility submits the Form CMS-382 to the appropriate intermediary. The intermediary then processes information from the form to CWF. See Chapter 8 for instructions for completing the form.

DMERCs deny Method II claims where there is no method selection or the method selection has a value of '1' on file at CWF.

B - Changes in Method Selection

If a beneficiary decides to change his or her choice of method selection, he or she must fill out a new Form CMS-382 to indicate the change. The beneficiary may fill out a new method selection form at any time, but in most circumstances, the change will not take effect until January 1 of the following calendar year. If a beneficiary requests an exception to the January 1 implementation date in writing from the intermediary, the intermediary may choose to grant his or her request. See Chapter 8 for related requirements.

DMERC systems must be able to interpret the CWF trailer record that contains the method effective date

C - Examples

Example 1 - A beneficiary decides to change his or her method selection choice from Method I to Method II, and completes a new Form CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002, and does not request an exception to the January 1 effective date.

In this example, the intermediary enters an effective date of January 1, 2003, for the beneficiary's change to Method II. The beneficiary remains a Method I patient until January 1, 2003, and the intermediary continues to process his or her claims with dates of service before that date. The DMERC begins processing

Method II claims for dates of service for the beneficiary on and after January 1, 2003. The beneficiary remains a Method II patient until he or she decides to complete another Form CMS-382 to change his or her method selection choice.

Example 2 - A beneficiary decides to change his or her method selection choice from Method I to Method II and completes a new Form CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002, and requests an exception to the January 1 effective date. The intermediary decides to grant the request and grants the beneficiary an effective date of November 1, 2002, for the method selection change.

In this example, the intermediary enters an effective date of November 1, 2002, for the beneficiary's change to Method II. The beneficiary remains a Method I patient for dates of service before November 1, 2002, and the intermediary continues to process his or her claims with dates of service before that date. The DMERC begins processing Method II claims for dates of service for the beneficiary on and after November 1, 2002. The beneficiary remains a Method II patient until he or she decides to complete another Form CMS-382 to change his or her method selection choice.

Example 3 - A beneficiary decides to change his or her method selection choice from Method I to Method II and completes a new Form CMS-382 on October 1, 2002. The beneficiary signs the form on October 1, 2002, and requests an exception to the January 1 effective date. The intermediary decides to deny the request for an exception to the January 1 effective date.

In this example, the intermediary enters an effective date of January 1, 2003, for the beneficiary's change to Method II. The beneficiary remains a Method I patient for dates of service before January 1, 2003, and the intermediary continues to process his or her claims with dates of service before that date. The DMERC begins processing Method II claims for dates of service for the beneficiary on and after January 1, 2003. The beneficiary remains a Method II patient until he or she decides to complete another Form CMS-382 to change his or her method selection choice.

30.8.2 - Installation and Delivery Charges for ESRD Equipment

(Rev.)

B3-5105.1

Medicare covers all reasonable and necessary expenses incurred in the initial installation of home dialysis equipment, but not those expenses attributable to items that are basically for the purpose of improving the patient's home, e.g., plumbing or electrical work beyond that necessary to tie in with existing power or water lines.

The delivery and installation of renal dialysis equipment, unlike that involved when a hospital bed is delivered and set up, requires testing and assurance of equipment performance. Therefore, if the supplier of home dialysis equipment customarily charges for delivery and service, and this is a common practice among other suppliers as well, this is payable.

40 - Payment for Maintenance and Service for Non-ESRD Equipment

(Rev.)

40.1 - General

(Rev.)

B3-5102.2.G, B3-5102.3

Contractors pay for maintenance and servicing of purchased equipment in the following classes:

- inexpensive or frequently purchased,
- customized items, other prosthetic and orthotic devices, and
- capped rental items purchased in accordance with §30.5.2 or §30.5.3.

They do not pay for maintenance and servicing of purchased items that require frequent and substantial servicing, or oxygen equipment. (Maintenance and servicing may be paid for purchased items in these two classes if they were purchased prior to June 1, 1989). Reasonable and necessary charges include only those made for parts and labor that are not otherwise covered under a manufacturer's or supplier's warranty. Contractors pay on a lump-sum, as needed basis based on their individual consideration for each item. Payment may not be made for maintenance and servicing of rented equipment other than maintenance and servicing for PEN pumps (under the conditions of §40.3) or the maintenance and servicing fee established for capped rental items in §40.2.

Servicing of equipment that a beneficiary is purchasing or already owns is covered when necessary to make the equipment serviceable. The service charge may include the use of "loaner" equipment where this is required. If the expense for servicing exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. Contractors investigate and deny cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment as discussed in BPM Chapter 15 where they determine that it is unreasonable to make program payment under the circumstances. Such cases are referred to the program integrity specialist in the RO.

40.2 - Maintenance and Service of Capped Rental Items

(Rev.)

A3-3629

For capped rental items which have reached the 15-month rental cap, contractors pay claims for maintenance and servicing fees after six months have passed from the end of

the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. For example:

Date service begins:	1/5/01
15-month rental period ends: 4/4/02	(1/5/01 + 15 months)
6-month period when no payment is made (4/5/02 + 6 months):	4/5/02 - 10/4/02
Date maintenance and servicing payment may begin:	10/5/02
Payment covers all maintenance and servicing through (10/5/02+ 6 months):	4/4/03

The maintenance and servicing fee for capped rental items may be paid only once every six months. However, in the event the beneficiary elected to purchase the equipment, maintenance and servicing are paid in accordance with the instructions in §40.1.

40.3 - Maintenance and Service of PEN Pumps

(Rev.)

B3-5017.4

Effective October 1, 1990, necessary maintenance and servicing of pumps after the 15-month rental limit is reached may include repairs and extensive maintenance that involves the breaking down of sealed components, or performing tests that require specialized testing equipment not available to the beneficiary or nursing home. The DMERC will pay only for actual incidents of maintenance, servicing, or replacement. For enteral pumps, no more than one-half rental payment may be paid every six months, beginning six months after the last rental payment. For parenteral pumps, no more than one-half the rental payment may be paid every three months, beginning three months after the last rental payment for the pump. The DMERC requests written proof from the supplier of maintenance and servicing of the pump.

50 - Payment for Replacement of Equipment

B3-5102.2.B

Replacement of equipment which the beneficiary owns or is purchasing or is a capped rental item is covered in cases of loss, or irreparable damage or wear, and when required because of a change in the patient's condition subject to the following provisions. Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when, in the contractor's judgment, the equipment as originally ordered, considering the age of the order, still fills the patient's medical needs. However, claims involving replacement equipment necessitated because of wear or a change in the patient's condition must be supported by a current physician's order.

(See Benefit Policy Manual Chapter 16, for payment for equipment replaced under a warranty.)

Contractors investigate and deny cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment as discussed in BPM Chapter 15, where it is determined that it is unreasonable to make program payment under the circumstances. They refer such cases to the program integrity specialist in the RO.

Contractors do not pay for replacement of rented equipment except capped rental items. (See §50.1) However, they pay for replacement of purchased equipment in the following classes: inexpensive or routinely purchased, customized items, capped rental (where the beneficiary has elected to purchase the item), and other prosthetic and orthotic devices. They do not pay for purchase or replacement of items that require frequent and substantial servicing or oxygen equipment.

50.1 - Payment for Replacement of Capped Rental Items

(Rev.)

A3-3629

Effective May 1, 1991, if a capped rental item of equipment has been in continuous use by the patient, on either a rental or purchase basis, for the equipment's useful lifetime or if the item is lost or irreparably damaged, the patient may elect to obtain a new piece of equipment. The contractor determines the reasonable useful lifetime for capped rental equipment but in no case can it be less than five years**.** This is a different requirement from that in the following section about prosthetic devices that are not capped rental. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the patient elects to obtain a new piece of equipment, payment is made on a rental or purchase basis.

50.2 - Payment for Replacement of Prosthetic Devices

(Rev.)

PM AB-01-06

Section 1834(h)(1)(G)(i) of the Act requires Medicare payment to be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.

Payment may be made for the replacement of a prosthetic device that is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;

2. An irreparable change in the condition of the device, or in a part of the device; or

3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

This provision applies to items replaced on or after April 1, 2001.

50.3 - Payment for Replacement of Parenteral and Enteral Pumps

(Rev.)

B3-3324

Payment for replacement of PEN pumps purchased more than eight years prior to the current date may be considered, with documentation that indicates proof of purchase date. Medicare will consider payment for either a replacement by purchase or 15 months of rental.

60 - Payment for Delivery and Service Charges for Durable Medical Equipment

(Rev.)

B3-5105

Delivery and service are an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. Such costs are ordinarily assumed to have been taken into account by suppliers (along with all other overhead expenses) in setting the prices they charge for covered items and services. As such, these costs have already been accounted for in the calculation of the fee schedules. Also, most beneficiaries reside in the normal area of business activity of one or more DME supplier(s) and have reasonable access to them.

Therefore, DME carriers may not allow separate delivery and service charges for oxygen or DME except as specifically indicated in §§90 or in rare and unusual circumstances when the delivery is not typical of the particular supplier's operation.

For example, there may be situations in which it is necessary for a DME dealer to incur extraordinary delivery expenses in order to meet the needs of beneficiaries living in remote areas that are not served by a local dealer or when a local dealer is temporarily out of stock of required oxygen or equipment. For example, DME carriers may recognize a reasonable separate delivery charge when the supplier must deliver an item of DME outside its normal area of business activity and the beneficiary does not have access to a supplier whose location is nearer.

When a supplier delivers oxygen or DME outside the area in which he/she normally does business, but the item could have been obtained locally, carriers may allow any separate additional delivery charge only to the extent that it does not raise the total payment for the oxygen or DME above the local fee schedule.

When a separate charge can be allowed for delivery/service, carriers base the amount (based on mileage or a flat rate) on all of the relevant circumstances, including:

- The time and distance traveled;
- The actual additional expenses incurred by the supplier;
- The type and quantity of equipment or oxygen delivered;
- The supplier's customary charge under such circumstances;
- The prevailing charges in the locality under such circumstances; and
- Delivery charges made elsewhere in similar localities. Any separate delivery charges recognized because of unusual circumstances may, of course, be paid for only for deliveries that have actually been made.

Suppliers must be advised in the carrier service areas to bill a separate delivery charge only in those rare situations in which "unusual circumstances" were encountered. Information issuances should be used to advise DME suppliers of the need to fully document unusual circumstances on claims/bills for separate delivery charges. If a supplier, nevertheless, routinely itemizes delivery charges, carriers may consider payment for the charges to be included in the fee for the equipment.

80 - Penalty Charges for Late Payment Not Included in Reasonable Charges or Fee Schedule Amounts

(Rev.)

B3-5106.1

Penalty charges imposed on a beneficiary by a physician or supplier because of failure to make timely payment on a bill are not covered under Medicare.

NOTE: The Judicial Council of the American Medical Association has ruled that, "It is not in the best interest of the public or the profession to charge a penalty if fees for professional services are not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the amount to an agency for collection."

90 - Payment for Additional Expenses for Deluxe Features

(Rev.)

B3-5107, PM AB-02-114

The payment amount for a given service or item, whether rented or purchased, must be consistent with what is reasonable and medically necessary to serve the intended purpose (See Benefit Policy Manual Chapter 15, §110.2). Additional expenses for "deluxe" features, or items that are rented or purchased for aesthetic reasons or added convenience, do not meet the reasonableness test. Thus, where a service or item is medically necessary and covered under the Medicare program, and the patient wishes to obtain such deluxe features, the payment is based upon the payment amount for the kind of service or item normally used to meet the intended purpose (i.e., the standard item.) Usually this is the least costly item. Carriers may, of course, determine that the payment amount for a more expensive service or item is reasonable when the additional expense is for an added feature that is medically necessary in a given case. For example, a more expensive item may be medically necessary where a patient in a weakened condition needs a power-operated wheelchair or a power-operated vehicle that may be appropriately used as a wheelchair since the patient is not strong enough to operate a manual wheelchair.

Finally the provider may not charge the beneficiary for features not medically required by his/her condition and which cannot be considered in determining the provider's allowable costs unless the beneficiary or her/his representative has specifically requested the excessive or deluxe items or services with knowledge of the amount s/he is to be charged. An Advance Beneficiary Notification (ABN) is required as documentation that the beneficiary has made such an informed request. See Chapter 1, §60 for ABN requirements.

The acceptance of an assignment binds the supplier-assignee to accept the allowed charge for the medically required equipment or service as the full charge and he cannot charge the beneficiary the differential attributable to the equipment actually furnished.

Only if a more expensive item or model with special features is medically necessary for the beneficiary will the allowed charge be based on the more expensive model. If the patient purchases or rents an item of durable medical equipment having more expensive features than his condition requires, the supplier accepting assignment on such an item cannot charge or collect any amount in excess of the allowed charge for the appliance adequate for the patient's needs. Acceptance of assignment binds the supplier to accept the allowed charge determined by the contractor, as the full charge for the item. A supplier who wishes to charge and collect the full price for equipment more expensive than medically required by the patient need not accept assignment. In assignment cases, the beneficiary is responsible for paying the supplier the unpaid balance of the allowed charge when payments stop because his condition has changed and the equipment is no longer medically necessary. Similarly, when payments stop because the beneficiary dies, his/her estate is responsible to the supplier for such unpaid balance.

100 - General Documentation Requirements

(Rev.)

B3-4107.1, B3-4107.8, HHA-463, Medicare Handbook for New Suppliers: Getting Started, B-02-31

Benefit policies are set forth in the Medicare Benefit Policy Manual, Chapter 15, §§110-130.

Program integrity policies for DMEPOS are set forth in the Medicare Program Integrity Manual, Chapter 5.

See Chapter 21 for applicable MSN messages.

See Chapter 22 for Remittance Advice coding.

100.1 - Written Order Prior to Delivery

(Rev.)

See Program Integrity Manual, Chapter 5, §§1.1, for requirements for written orders for suppliers, including providers billing the DMERC or carrier as suppliers.

See §01 for definitions of provider and supplier.

100.1.1 Written Order Prior to Delivery - HHAs

(Rev.)

See Program Integrity Manual, Chapter 6, §3.3. These instruction apply to bill types 32x, 33x and 34x.

100.2 - Certificates of Medical Necessity (CMN)

(Rev.)

B3-3312

For certain items or services billed to the DME Regional Carrier (DMERC), the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician. CMNs are not required for the same items when billed by HHAs to RHHIs. Instead, the items must be included in the physician's signed orders on the home health plan of care. See Program Integrity Manual, Chapter 6, §3.3.

The intermediary will inform other providers (see §01 for definition pf provider) of documentation requirements.

Contractors may ask for supporting documentation beyond a CMN.

Refer to the local DMERC Web site described in §10 for downloadable copies of CMN forms.

See Chapter 5, §7, of the Medicare Program Integrity Manual for specific Medicare policies and instructions on the following topics:

- Requirements for supplier retention of original CMNs
- CMN formats, paper and electronic
- List of currently approved CMNs and items requiring CMNs
- Supplier requirements for submitting CMNs
- Requirements for CMNs to also serve as a physician's order
- Civil monetary penalties for violation of CMN requirements
- Supplier requirements for completing portions of CMNs
- Physician requirements for completing portions of CMNs

100.2.1 - Completion of Certificate of Medical Necessity Forms

(Rev.)

1. SECTION A: (This may be completed by supplier.)

    a. Certification Type/Date - If this is an initial certification for this patient, the date (MM/DD/YY) is indicated in the space marked "INITIAL". If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), the initial date is indicated in the space marked "INITIAL", **and** the revision date is indicated in the space marked "REVISED". If this is a recertification, the initial date is indicated in the space marked "INITIAL", **and** the recertification date is indicated in the space marked "RECERTIFICATION". Whether a REVISED or RECERTIFIED CMN is submitted, the INITIAL date as well as the REVISED or RECERTIFICATION date is always furnished.

    b. Patient Information - This indicates the patient's name, permanent legal address, telephone number, and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

    c. Supplier Information - This indicates the name of the company (supplier name), address, telephone number, and the Medicare supplier number assigned by the National Supplier Clearinghouse (NSC).

d. Place of Service - This indicates the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, or end stage renal disease (ESRD) facility is 65. See chapter 23 for place of service codes.

e. Facility Name - This indicates the name and complete address of the facility, if the place of service is a facility.

f. HCPCS Codes - This is a list of all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification are not listed on the CMN.

g. Patient Date of Birth (DOB), Height, Weight, and Sex - This indicates patient's DOB (MM/DD/YY), height in inches, weight in pounds, and sex (male or female).

h. Physician Name and Address - This indicates the treating physician's name and complete mailing address.

i. UPIN - This indicates the treating physician's unique physician identification number (UPIN).

j. Physician's Telephone Number - This indicates the telephone number where the treating physician can be contacted (preferably where records would be accessible pertaining to this patient) if additional information is needed.

2. SECTION B: (This may not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed by the treating physician. Contractors publish this requirement about section B in their bulletins at least annually.)

a. Estimated Length of Need - This indicates the estimated length of need (the length of time (in months) the physician expects the patient to require use of the ordered item). If the treating physician expects that the patient will require the item for the duration of his/her life, 99 is entered. For recertification and revision CMNs, the cumulative length of need (the total length of time in months from the initial date of need) is entered.

b. Diagnosis Codes - Listed in the first space is the ICD-9 code that represents the primary reason for ordering this item. Additional ICD-9 codes that would further describe the medical need for the item (up to 3 codes) are also listed. A given CMN may have more than one item billed, and for each item, the primary reason for ordering may be different. For example, a CMN is submitted for a manual wheelchair (K0001) and elevating leg rests (K0195). The primary reason for K0001 is stroke, and the primary reason for K0195 is edema.

c. Question Section - This section is used to gather clinical information regarding the patient's condition, the need for the DME, and supplies.

d. Name of Person Answering Section B Questions - If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician, or a physician employee) answers the questions in section B, he/she must **print** his/her name, give his/her professional title, and the name of his/her employer, where indicated. If the **treating physician** answered the questions, this space may be left blank.

3. SECTION C: (This is completed by the supplier.)

   a. Narrative Description of Equipment and Cost - The supplier indicates (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies, and drugs; (2) the supplier's charge for each item, option, accessory, supply, and drug; and (3) the Medicare fee schedule allowance for each item, option, accessory, supply, or drug, if applicable.

4. SECTION D: (This is completed by the treating physician.)

   a. Physician Attestation - The treating physician's signature certifies the CMN that he/she is reviewing includes sections A, B, C, and D, the answers in section B are correct, and the self-identifying information in section A is correct.

   b. Physician Signature and Date - After completion and/or review **by the treating physician** of sections A, B, and C, the treating physician must sign and date the CMN in section D, verifying the attestation appearing in this section. The treating physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Certifications and recertifications may not be altered by "whiting out" or "pasting over" and entering new data. Such claims are denied and suppliers that show a pattern of altering CMNs are identified for educational contact and/or audit.

Also suppliers who have questionable utilization or billing practices or who are under sanction are considered for audit.

100.2.2 - Evidence of Medical Necessity for Parenteral and Enteral Nutrition (PEN) Therapy

(Rev.)

B3-3324, B3-4450

PEN coverage is determined by information provided by the treating physician and the PEN supplier. A completed certification of medical necessity (CMN) must accompany and support initial claims for PEN to establish whether coverage criteria are met and to ensure that the PEN therapy provided is consistent with the attending or ordering physician's prescription. Contractors ensure that the CMN contains pertinent information

from the treating physician. Uniform specific medical data facilitate the review and promote consistency in coverage determinations and timelier claims processing.

The medical and prescription information on a PEN CMN can be most appropriately completed by the treating physician or from information in the patient's records by an employee of the physician for the physician's review and signature. Although PEN suppliers sometimes may assist in providing the PEN services, they cannot complete the CMN since they do not have the same access to patient information needed to properly enter medical or prescription information. Contractors use appropriate professional relations issuances, training sessions, and meetings to ensure that all persons and PEN suppliers are aware of this limitation of their role.

When properly completed, the PEN CMN includes the elements of a prescription as well as other data needed to determine whether Medicare coverage is possible. This practice will facilitate prompt delivery of PEN services and timely submittal of the related claim.

100.2.2.1 - Scheduling and Documenting Certifications and Recertifications of Medical Necessity for PEN

(Rev.)

A certification for PEN therapy must accompany the initial claim submitted. The initial certification is valid for six months. Contractors establish the schedule on a case-by-case basis for recertifying the need for PEN therapy. A change in prescription for a beneficiary past the initial certification period does not restart the certification process.

A period of medical necessity ends when PEN services are not medically required for 2 consecutive months. The entire certification process, if required, begins after 2 consecutive months have elapsed.

A revised certification or a change in prescription may impact on the payment levels of PEN services. A revised certification is appropriate when there is a change:

- In the treating physician's orders in the category of nutrients and/or calories prescribed;
- By more than one liter in the daily volume of parenteral solutions;
- From home-mix to pre-mix or pre-mix to home-mix parenteral solutions;
- From enteral to parenteral or parenteral to enteral therapy; or
- In the method of infusion (e.g., from gravity-fed to pump-fed).

100.2.2.2 - Completion of the Elements of PEN CMN

(Rev.)

The patient's name, address, and HICN and the nature of the certification (i.e., initial, renewed, or revised) must be entered on all certifications by the supplier, physician, or physician's designated employees. The supplier identifying information is required on all PEN certifications.

All medical and prescription information must be completed from the patient's records by the attending/ordering physician, or an employee of the physician authorized to act on the physician's behalf, and reviewed and signed by the physician.

1. Place of Service - The CMN must identify the site where the patient is receiving PEN services. A patient may receive services at home, in a nursing home setting (e.g., skilled nursing facility), or another site that must be indicated by the supplier/physician.

2. Patient's General Condition - The attending physician must complete information about the patient's age, height, and weight. The general condition of the patient also includes an estimated duration of therapy (i.e., in months, years, or for life), the ambulatory status, and whether the patient is conscious. The physician should also indicate food allergies/sensitivities, other medical treatments, therapies, and/or medical conditions that may affect the patient's nutritional needs.

3. Patient's Clinical Assessment - The attending physician must indicate all the diagnoses related to the PEN therapy and describe the patient's functional impairment of the digestive tract that precludes the enteral patient from swallowing and the parenteral patient from absorbing nutrients. The physician must certify that PEN therapy meets the requirement that a patient is not able to maintain weight and strength due to pathology or nonfunction of the ingestion system and that the enteral therapy serves as the source of nutrition for the patient who has a functioning digestive tract, but whose disability prevents ingestion of sufficient nutrients to the alimentary tract for metabolism. Nutritional supplements for patients capable of ingesting normally, even if required to maintain weight and strength, cannot be covered under the prosthetic device benefit. The physician must have a basis for certifying or recertifying the need for PEN services. The physician is expected to see the patient within 30 days prior to certifying or recertifying PEN services. However, if the physician did not see the patient, he/she must explain why and describe what other monitoring methods were used to evaluate the patient's PEN needs.

4. Patient's Nutritional Prescription - Subsequent to an examination of the patient and/or a review of the patient's medical information, the attending physician must complete the patient's nutritional requirements (prescription) to certify the PEN therapy provided.

For the parenteral patient, the CMN must contain the following information:

- The infusion frequency per week,
- The route of administration,
- A reason for the use of pre-mixed parenteral formulas,
- An explanation for the use of special formulas such as hepatic, renal, or stress
- formulas, and
- The amino acid/dextrose formula components of the parenteral solution mix.

Amino acids serve as a source of protein. Adult parenteral nutrition patients generally need 1 to 1.5 grams of protein per day for each kilogram (2.2 pounds) of body weight. Dextrose concentrations less than 10 percent must be explained by the physician. The physician must document the reason for using more than 12 units (@ 500ml per unit) of lipids per month.

Parenteral nutrition may be either "self-mixed" (i.e., the patient is taught to prepare the nutrient solution aseptically) or "pre-mixed" (i.e., the nutrient solution is prepared by trained professionals employed or contracted by the PEN supplier). The attending physician must provide information to justify the reason for "pre-mixed" parenteral nutrient solutions.

Renal dialysis patients sometimes undergo parenteral therapy to replace fluids and nutrients lost during dialysis. Patients are usually infused less than daily and parenteral feeding is often supplemental and, therefore, not covered as a PEN benefit. The renal dialysis patient must meet all the requirements for PEN coverage. The attending physician must document that the patient, despite the need for renal dialysis, suffers from a permanently impaired functional impairment that precludes swallowing or absorption of nutrients.

For the enteral patient, the attending physician must include the following information on the CMN:

- The name of the nutrient product or nutrient category,
- The number of calories per day (100 calories = 1 unit),
- The frequency per day,
- The method of administration (i.e., syringe, gravity, or pump),
- The route of administration (i.e., nasogastric tube, gastrostomy tube, jejunostomy tube, percutaneous enteral gastrostomy tube, or naso-intestinal tube), and
- The reason for the use of a pump.

Categories of enteral nutrition are based on the composition and source of ingredients in each enteral nutrient product. Category IB of enteral nutrients contains products that are natural intact protein/protein isolates commonly known as blenderized nutrients. Additional documentation is required to justify the necessity of Category IB nutrients. The attending physician must provide sufficient information to indicate that the patient:

- Has an intolerance to nutritionally equivalent (semi-synthetic) products;
- Had a severe allergic reaction to a nutritionally equivalent (semi-synthetic) product; or
- Was changed to a blenderized nutrient to alleviate adverse symptoms expected to be of permanent duration with continued use of semi-synthetic products.

Enteral nutrient categories III through VI require additional medical justification for coverage. These categories represent formulas for special needs or use.

- Category III (code B4153): hydrolyzed protein/amino acids. These products contain a high nitrogen availability as a result of chemical treatment to reduce high molecular protein compounds into smaller molecules and amino acids that are easier to digest.
- Category IV (code B4154): defined formulas for special metabolic needs and conditions such as abnormal glucose tolerance, renal disease, liver disease, HIV, respiratory insufficiency, and malnutrition.
- Category V (code B4155): modular components (proteins, carbohydrates, fats).
- Category VI (code B4156): standardized nutrients. These products contain low residue ingredients.

If the patient exhibits a problem with any particular formula in Nutrient Category I (HCPCS B4150) or II (HCPCS B4152), the physician must document the unfavorable events that resulted in prescribing a higher category formula.

Generally, daily enteral intake of 750 to 2,000 calories is considered sufficient to maintain body weight. Patients with medical complications may require an intake outside the range. The attending physician must document the reason for prescribing less than 750 calories per day or more than 2000 calories per day.

Enteral nutrition may be administered by syringe, gravity, or pump. The attending physician must specify the reason that necessitates the use of an enteral feeding pump. Some enteral patients may experience complications associated with syringe or gravity method of administration. Contractors provide coverage for enteral pumps if the medical necessity is documented by the attending physician on the CMN. Examples of circumstances that indicate the need for a pump include, but are not limited to:

- Aspiration or Dumping Syndrome;

- Severe diarrhea remedied by regulated feeding;

- Insulin-dependent diabetics who require a flow rate of less than 100cc's per hour for proper regulation of nutrients;

- Patients with congestive heart failure who require a pump to prevent circulatory overload; or

- Patients with a jejunostomy tube for feeding.

The DMERC reviews the claims to ensure that the equipment for which payment is claimed is consistent with that prescribed (e.g., expect a claim for an I.V. pole, if a pump is used).

5. Attending Physician's Signature and Identification - A handwritten, original signature and date must be on each certification. The form must be dated to show reasonable association to the dates of active PEN therapy. The full name, address, telephone number (including area code), and Unique Physician Identification Number (UPIN) allows the contractor to determine if the prescriber is authorized to order Medicare services and facilitate claims development.

6. PEN Supplier's Identification - The PEN supplier's name, address, telephone number, and PEN identification number must be on each certification. This information allows the contractor to determine if the supplier is authorized to provide PEN supplies and facilitate claims development.

100.2.2.3 - DMERC Review of Initial PEN Certifications

(Rev.)

B3-4450

In reviewing the claim and the supporting data on the CMN, the DMERC compares certain items, especially pertinent dates of treatment. For example, the start date of PEN coverage cannot precede the date of physician certification. The estimated duration of therapy must be contained on the CMN. This information is used to verify that the test of permanence is met. Once coverage is established, the estimated length of need at the start of PEN services will determine the recertification schedule.

The information shown on the certification must support the need for PEN supplies as billed. A diagnosis must show a functional impairment that precludes the enteral patient from swallowing and the parenteral patient from absorbing nutrients.

Initial assigned claims with the following conditions are denied without development:

- Inappropriate or missing diagnosis or functional impairment;

- Estimated duration of therapy is less than 90 consecutive days;

- Duration of therapy is not listed;
- Supplies have not been provided;
- Supplies were provided prior to onset date of therapy; and
- Stamped physician's signature.

Unassigned claims are developed for missing or incomplete information.

A - Revised Certifications/Change in Prescription

A revised certification is required when:

- There is a change in the attending physician's orders in the category of nutrients and/or calories prescribed;
- There is a change by more than one liter in the daily volume of parenteral solutions;
- There is a change from home-mix to pre-mix or pre-mix to home-mix parenteral solutions;
- There is a change from enteral to parenteral or parenteral to enteral therapy; or
- There is a change in the method of infusion (e.g., from gravity-fed to pump-fed).

PEN payments are not adjusted unless a revised or renewed certification documents the necessity for the change. Payment levels for the most current certification or recertification may not be changed unless a prescription change is documented by a new recertification.

The DMERC may adjust the recertification schedule as needed.

100.2.3 - Evidence of Medical Necessity for Oxygen

(Rev.)

B3-4105

Oxygen coverage is determined by the results of an arterial blood gas or oximetry test. A CMN for oxygen equipment must include results of specific testing before coverage can be determined.

Suppliers that bill electronically may transmit initial, revised, and recertification CMNs by electronic media using CMS-established standard formats. Information transmitted from a revised or recertification Form CMS-484 must accompany the first claim for monthly benefits submitted after the supplier has received the hard copy Form CMS-484 from the certifying physician. If the supplier submits Form CMS-484 information to the

contractor electronically, the supplier must keep the paper certification readily available so that it may be promptly furnished to the contractor if requested for purposes of audits of medical necessity documentation.

Blood Oxygen Testing

The medical necessity of home oxygen is documented by the results of a blood oxygen test. The blood oxygen test may be either an arterial blood gas or an oximetry test. The following timeliness requirements must be met.

Initial Certification:

Groups I and II: Must be tested within 30 days prior to the date of initial certification. If the oxygen is begun immediately following discharge from an acute care facility, the test must be within two days prior to discharge.

Recertification:

Group I: Retesting requirements are to be determined by the contractor.

Group II: Must be retested between the 61st - 90th day after the date of the initial certification.

Revised Certifications:

Group I and II: Must be tested within 30 days prior to the date of the revised certification if the initial certification specified a length of need that is less than lifetime.

Physician Evaluation

Initial Certification:

Groups I and II: Must be seen and evaluated by the treating physician within 30 days prior to the date of initial certification

Recertifications:

Group I and II: Must be seen and re-evaluated by the treating physician within 90 days prior to any recertification date.

A - Initial Certifications

In reviewing the claim and the supporting data, contractors compare certain items, especially pertinent dates of treatment. For example, the start date of home oxygen coverage cannot precede the date of prescription or the date of the test(s) whose results establish that the special coverage criteria are met. Once coverage is established, the estimated length of need in Section B on the Form CMS-484, and the circumstances and the results of testing that established the medical necessity at the start of home oxygen therapy, determines the recertification schedule.

Definitions of "Group" based on blood gas values:

Group I - An arterial PO_2 at or below 55 mm Hg, or arterial blood oxygen saturation at or below 88 percent.

Group II - An arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89 percent.

Group III - An arterial PO_2 at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90 percent.

When oxygen is prescribed in an institution, in order to establish medical necessity it is necessary that the institution would have to recheck the oxygen level no sooner than 2 days before discharge.

Clinical documentation will be reviewed to confirm the fact that the prescribing of continued oxygen was based upon the "chronic stable state" (was done while the patient was in a chronic stable state - i.e., not during a period of acute illness or an exacerbation of the patient's underlying disease) of the patient.

Contractors verify that the information shown on or accompanying the Form CMS-484 or other CMN supports the need for oxygen as billed.

When both arterial blood gas (ABG) and oxygen saturation (oximetry) tests have recently been performed on the same day, suppliers report only the ABG result. That test is generally acknowledged as the more reliable indicator of hypoxemia.

Test results from oximetry tests performed by a DME supplier, or anyone financially associated with or related to the DME supplier, are not acceptable.

Values in Group III establish a rebuttable presumption of non-coverage. The CMN must be supplemented by additional documentation from the treating physician designed to overcome this presumption and justify the oxygen order, including a summary of other, more conservative therapy that has not relieved the patient's condition. Claims with such documentation are referred to the contractor's medical director for the coverage determination.

The following types of claims are denied without further development:

- Claims where the only qualifying test results came from oximetry tests conducted by a DME suppliers other than a hospital;
- Claims lacking information necessary to justify coverage;
- Hard copy claims where the CMN or Form CMS-484 lacks the treating physician's signature; or

- Electronic claims where the CMN or Form CMS-484 fails to indicate that the treating physician's handwritten signature is on file in the supplier's office.

An initial CMN is also required when there has been a break in medical necessity of 60 days plus whatever days remained in the rental month during which the oxygen was discontinued. (This indication does not apply if there was just a break in billing because the patient was in a hospital, nursing facility, hospice, or HMO, but the patient continued to use oxygen during that time.)

B - Revised Certifications

Contractors encourage treating physicians to file timely, revised CMNs or Form CMS-484s through the supplier if their order for oxygen changes.

A revised CMN is necessary when:

1. The prescribed maximum flow rate changes from one of the following categories to another: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the beneficiary on 4 LPM must be performed within 30 days prior to the start of the greater than 4LPM flow.

2. Portable oxygen is added subsequent to initial certification of a stationary system. In this situation, there is no requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the patient is at rest (awake) or during exercise.

3. The initial certification specified an estimated length of need that is less than lifetime and the physician wants to extend the certification.

4. There is a new treating physician (no new testing is required).

Contractors do not adjust payments on oxygen claims unless a revised certification documents the necessity for the change. Contractors timely adjust payments, if necessary, for services since the oxygen prescription was changed.

100.2.3.1 - Scheduling and Documenting Recertifications of Medical Necessity for Oxygen

(Rev.)

Recertification scheduling and documentation requirements depend on the date when home oxygen therapy began. Contractors request the following information on all recertifications:

- Date and results of the most recent arterial blood gas or oximetry tests prior to the recertification date;

- Name of the provider conducting the most recent arterial blood gas or oximetry tests performed prior to the recertification date and the conditions under which this test were conducted; and

- Estimated length of need for oxygen (Section B on the Form CMS-484).

Contractors establish the schedule for recertifying the need for oxygen for patients beginning home oxygen therapy in accordance with the requirements below:

1. Recertifications

Group I: Recertification requirements are to be determined by the contractor.

Group II: If oxygen test results on the initial certification were in Group II, according to §1834(a)(5) of the Act, recertification of all oxygen patients must be performed within 90 days after initial certification for all patients who begin coverage after January 1, 1991, with an arterial blood gas result at or above a partial pressure of 55 mm Hg or an arterial oxygen saturation percentage at or above 89. Repeat blood gas study must be performed between the 61st - 90th day of home oxygen therapy. Retesting is required only if a claim for oxygen therapy will be filed for the fourth or later months.

If recertification is due, contractors do not pay the next month's claim if the test was not performed during the required time frame. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the patient continues to use oxygen and a test is obtained at a later date, contractors instruct suppliers to use the date of the repeat test as the date of service on a subsequent claim, and if that test meets Group II criteria, they resume payments from that point of time.

2. New Orders - In the following situations, a new order must be obtained and kept on file by the supplier, but neither a new CMN nor a repeat blood gas study are required:

- If the prescribed maximum flow rate changes but remains within one of the following categories: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM

- If the physician has initially specified a delivery system, and a change is made from one type of stationary system to another (i.e., concentrator, liquid, gaseous).

100.2.3.2 - HHA Recertification for Home Oxygen Therapy

(Rev.)

Section 1834(a)(5) of the Act requires patients who receive home oxygen therapy and who at the time such services are initiated have an initial arterial blood gas value of 56 or higher or an initial oxygen saturation at or above 89 percent to be retested between 60 and 90 days after the start of oxygen therapy in order to continue to receive payment. HHAs must initiate the request for the retesting as promptly as possible because the recertification at three months must reflect the results of an arterial blood gas or oxygen

saturation test conducted between the 61st and 90th day of home oxygen therapy. Payment for the fourth month of home oxygen therapy is possible only if the patient's attending physician certifies that retesting results establish the continuing medical necessity for the services. The physician must certify based on the test of the patient's arterial blood gas value or oxygen saturation that there is a medical need for the patient to continue to receive oxygen therapy.

Value codes have been assigned for HHA reporting of the arterial blood gas and oxygen saturation. (FLs 39-41 on UB-92, HI segment on ANSI 837.) HHAs report value code 58 or 59 on every initial bill for home oxygen therapy and on the fourth month's bill.

For patients receiving oxygen therapy, who are not under a plan of care (bill type 34X), HHAs obtain a physicians recertification of the retesting and maintain a copy in their files for verification.

For patients receiving oxygen therapy, who are under a plan of care (bill types 32X and 33X), HHAs obtain a physician's recertification of the retesting and reflect this on Form CMS-485 or CMS-486 for verification.

RHHIs do not continue to make payment where the HHA fails to have the patient retested to determine continuing need of oxygen therapy within the specified time frames.

100.2.3.3 - Contractor Review of Oxygen Certifications

(Rev.)

All claims with initial certifications calling for oxygen flow rates of more than 4 liters per minute must be reviewed before payment is authorized.

Items Requiring Special Attention -

a. Oxygen Delivery or Supply Prescribed - If the treating physician has specified the oxygen equipment to be supplied, contractors ensure that the equipment furnished is consistent with that prescribed.

b. Treating Physician Identification - Contractors must ensure that the CMN or Form CMS-484 has been signed by the treating physician. A stamped signature is unacceptable. The physician's identification number must be the Unique Physician Identification Number (UPIN).

100.3 - Limitations on DMERC Collection of Information

(Rev.)

B-02-031

The Paperwork Reduction Act (PRA) of 1995 §44 USC 3500, et seq. requires that the Director of the Office of Management and Budget approve any collections of information

performed by or for the Federal Government unless the collection fits within exceptions for audits and investigations. Absent such approval, the collection violates the PRA and agencies may not hold the public to the requirement. Therefore, DMERCs must adhere to the following:

1. Power operated vehicles additional documentation requirements

A Certificate of Medical Necessity (CMN) must accompany initial claims for power operated vehicles (POV). Except during the course of audits and investigations, DMERCs must not require that additional documentation accompany all POV claims. DMERCs may continue requesting information during the course of audits and investigations and when developing individual claims on either a pre- or a post-payment basis. If DMERCs choose to conduct such investigations, they must follow the guidelines in the Program Integrity Manual, Chapter 3, §2.

2. Power wheelchair additional documentation requirements re: make and model name/number

There must be no requirement that all claims for power wheelchairs include the make and model name/number of the wheelchair separate from the claim or the CMN.

The CMN, an OMB approved information collection form, can be used to collect this information. Specifically, DMERCs can require that the make and model name/ number of the power wheelchair be included in Section C of the CMN. Section C requires the supplier to include a narrative description of the items, options and accessories ordered.

3. Power wheelchair additional documentation requirements re: functional abilities

There must be no requirement for suppliers to submit additional documentation to describe a beneficiary's medical condition and functional abilities when the supplier bills for a higher level of equipment than previously supplied.

While it is appropriate to avoid paying for duplicate equipment, it is inappropriate to require this documentation for all claims for "higher level equipment." DMERCs may choose to perform pre- or post- payment probe samples to review these types of claims individually in order to determine medical necessity. If DMERCs choose to conduct such investigations, they must follow the guidelines in the Program Integrity Manual, Chapter 3, §2.

110 - General Billing Requirements - for DME, Prosthetics, Orthotic Devices, and Supplies

(Rev.)

A3-3629

Part B suppliers and all providers other than HHAs must bill DMEPOS to the Durable Medical Equipment Regional Carrier (DMERC) except claims for implanted DME that

are billed to the local carrier. Suppliers and providers that wish to bill as suppliers must have a supplier billing number issued by the National Supplier Clearinghouse (NSC) prior to billing the DMERC.

DMEPOS provided under a home heath plan of care may be billed either by the HHA or by the supplier (including the HHA with a supplier number if the HHA prefers to bill that way). If the HHA chooses to bill to the RHHI, the HHA includes the DME on the PPS claim (32x or 33x). If the beneficiary not under a plan of care receives DMEPOS from a home health agency the agency uses bill type 34x.

Hospital outpatient departments bill their intermediary for prosthetic and orthotic devices and supplies.

Intermediaries must return any claims from where only DMEPOS services are included inappropriately, and inform the provider to bill the DMERC or local carrier as appropriate. Where a claim contains DMEPOS and other line items, intermediaries have the option of returning the claim or denying the DMEPOS portion.

110.1 - Billing/Claim Formats

(Rev.)

A3-3629

The DMERC and the local carrier are billed on Form CMS-1500 or the electronic equivalents. These are the National Standard Formats **(**NSF) or currently accepted ANSI ASC X12N 837P formats.

The intermediary (including the RHHI) is billed on Form CMS-1450 (the UB-92) or the electronic equivalents. These are the UB-92 electronic format and currently accepted ANSI ASC X12N 837I formats.

Note that the X12N formats do not support CMNs, and billers that use the X12N formats must send CMNs on either paper or the NSF or UB-92 formats, as applicable.

110.2 - Application of DMEPOS Fee Schedule

(Rev.)

Services that are paid under the DME fee schedule are identified in the DMEPOS fee schedule file available free on the CMS Web Site at:
http://www.cms.hhs.gov/providers/pufdownload/default.asp

The DMEPOS fee schedule applies to claims to intermediaries as follows.

BILL TYPE/ DEFINITION	ORTHOTICS/ PROSTHETICS	DME/ OXYGEN
12X (Hospital inpatient Part B)	Subject to fee schedule	Not covered, therefore, not subject to fee schedule
13X (Hospital Outpatient)	Subject to fee schedule	Subject to fee schedule
22X (SNF inpatient Part B)	Subject to fee schedule	Not covered, therefore, not subject to fee schedule
23X (SNF outpatient)	Subject to fee schedule	Subject to fee schedule
*32X (HHA visits under Part B Plan of Care)	Subject to fee schedule	Subject to fee schedule
*33X (HHA visits under Part A Plan of Care)	Subject to fee schedule	Subject to fee schedule
34X (HHA visits not under a Plan of Care)	Subject to fee schedule	Subject to fee schedule
71X Rural health clinics (Provider-based only)	Subject to fee schedule	Subject to fee schedule
74X (Outpatient PT)	Subject to fee schedule	Subject to fee schedule
75X (CORF)	Subject to fee schedule	Subject to fee schedule
**83X ASC	Subject to fee schedule	Subject to fee schedule
85X RPCH	Subject to fee schedule	Subject to fee schedule

* HCPCS codes A4214, A4310 through A4455, A4481, A4622, A4623, A4625, A4626, A4629, and A5051 through A5149 are excluded from the fee schedule when billed by a HHA to its RHHI under these bill types. Also, when billed on type of bill 32x or 33, catheter and ostomy supplies are considered non-routine supplies and are billed with revenue code 27x.

** HCPCS codes A4214, A4310 through A4330, A4338 through A4359, and A5102 through A5114 are excluded from the fee schedule when billed by a non-OPPS hospital with an ASC service under this bill type. In addition, HCPCS codes A5119 through A5131 can be excluded or included in the fee schedule depending on the procedure in which they are associated.

NOTE: Bill types not listed are not subject to the fee schedule for either orthotics/ prosthetics or DME/oxygen with the exception of provider-based Federally Qualified Health Centers (FQHCs). Orthotics/prosthetics and DME/oxygen furnished by provider-based FQHCs are subject to the fee schedule. However, bill type 73X is not reflected in the above chart since FQHCs use the bill type for the parent provider (usually 13x).

Bill types listed above are billed to the intermediary for orthotics/prosthetics.

Providers other than HHAs bill the DMERC for DME/oxygen. HHAs bill their RHHI for DME/oxygen.

DME billing is not required on Home Health PPS claims. Home Health Agencies retain the option to bill services to Regional Home Health Intermediaries (RHHI) or have services provided under arrangements with a supplier that bills the DMERC.

110.3 - Pre-Discharge Delivery of DMEPOS for Fitting and Training

(Rev.)

B3-3011

The following are CMS policy and billing procedures regarding the circumstances under which a supplier may deliver durable medical equipment, prosthetics, and orthotics - but not supplies - to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary's home.

110.3.1 - Conditions That Must Be Met

(Rev.)

In some cases, it would be appropriate for a supplier to deliver a medically necessary item of durable medical equipment (DME), a prosthetic, or an orthotic - but not supplies - to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. CMS will presume that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter "item") is appropriate when all the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home.

2. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.

3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.

4. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary.

5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.

6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.

7. The supplier does not claim payment for the item for any day prior to the date of discharge.

8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.

9. The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home.

110.3.2 - Date of Service for Pre-Discharge Delivery of DMEPOS

For DMEPOS, the general rule is that the date of service is equal to the date of delivery. However pre-discharge delivery of items intended for use upon discharge are considered provided on the date of discharge. The following three scenarios demonstrate both the latter rule (when the date of service is the date of discharge) and related exceptions.

1. If the supplier leaves the item with the beneficiary two days prior to the date of discharge, and if the supplier, as a practical matter, need do nothing further to effect the delivery of the item to the beneficiary's home (because the beneficiary or a caregiver takes it home), then the date of discharge is deemed to be the date of delivery of the item. Such date must be the date of service **for purposes of claims submission**. (This is not an exception to the general DMEPOS rule that the date of service must be the date of delivery. Rather, it recognizes the supplier's responsibility - per condition five above - to ensure that the item is actually delivered to the beneficiary's home on the date of discharge.) No one may bill for the days prior to the date of discharge.

2. If the supplier fits the item to the beneficiary, or trains the beneficiary in its use while the beneficiary is in the facility, but thereafter removes the item and subsequently delivers it to the beneficiary's home, then the date of service must be the date of actual delivery of the item, provided such date is not earlier than the date of discharge.

3. If the supplier leaves the item at the facility and the beneficiary does not take the item home, or a third party does not send it to the beneficiary's home, or the supplier does not otherwise (re)deliver the item to the beneficiary's home on or before the date of discharge, the date of service must not be earlier than the actual date of delivery of the item, i.e., the actual date the item arrives, by whatever means, at the beneficiary's home.

110.3.3 - Facility Responsibilities During the Transition Period

(Rev.)

1. A facility remains responsible for furnishing medically necessary items to a beneficiary for the full duration of a beneficiary's stay. The DRG and PPS rates cover such items.

2. A facility may not delay furnishing a medically necessary item for the beneficiary's use or treatment while the beneficiary is in the facility. A facility may not prematurely remove a medically necessary item from the beneficiary's use or treatment on the basis that a supplier delivered a similar or identical item to the beneficiary for the purpose of fitting or training.

3. A facility may not, through a stratagem of relying upon a supplier to furnish such items, improperly shift its costs for furnishing medically necessary items to a beneficiary who is a resident in the facility to Medicare Part B.

   Nevertheless, beginning two days before the beneficiary's discharge, a facility may take reasonable actions to permit a supplier to fit or train the beneficiary with the medically necessary item that is for subsequent use in the beneficiary's home. These actions may include the substitution of the supplier-furnished item, in whole or in part, for the facility-furnished item during the beneficiary's last two inpatient days provided the substitution is both reasonable and necessary for fitting or training and the item is intended for subsequent use at the beneficiary's home.

4. For prosthetic and orthotic (P&O) items, the above restrictions apply to residents in a covered Part A stay. For DME, the above restrictions apply in a covered Part A or a Part B stay.

110.4 - Frequency of Claims for Repetitive Services (All Providers and Suppliers)

(Rev.)

HHAs include DMEPOS on bill types 32x or33x with home health visits bill at the freqency required for the home health. See Chapter 10 for home health billing requirements.

Other providers and suppliers, including home health agencies billing the intermediary on bill type 34x, submit claims on a monthly basis unless another policy that allows billing at a different frequency applies. For example suppliers may bill for more than one month's diabetic test strips.

Claims are submitted in sequence where there are cases of known continuous periods of service over an extended period (e.g., capped rental equipment or therapies). When there is a break in service (e.g. interruption of capped rental as the result of an extensive inpatient stay), suppliers should continue sequential billing when the services resume.

The purpose of these requirements is to avoid CMS operational expenditures, and at the same time simplify the review process

130 - Billing for Durable Medical Equipment (DME) and Orthotic/ Prosthetic Devices

(Rev.)

A3-3629, B3-4107.10, HHA-463, HO-441, OPT-253.7, SNF-260.4 partial, SNF-264.4, SNF-533, SNF-534, AB-01-126, B3-3010

See §01 for definition of provider and supplier.

130.1 - Provider Billing for Prosthetic and Orthotic Devices

(Rev.)

A3-3629

See §01 for definition of provider.

These items consist of all prosthetic and orthotic devices excluding parenteral/enteral nutritional supplies and equipment and intraocular lenses.

Prosthetics and orthotic devices are included in the Part A PPS rate unless specified as being outside the rate. For SNFs, customized prosthetic devices that are not included in the Part A PPS rate and which may be billed separately are identified in the SNF HCPCS HELP file. Click here to access the file electronically. The file is updated as CMS determines appropriate. It describes HCPCS codes for services included in Part A consolidated billing, the services separately billable by the SNF or supplier under Part B for Part A and/or Part B inpatients, and services that may be billed by a supplier but not by SNF. If these latter services are billed by the SNF, no additional payment will be made. If the SNF or hospital wants also to be a supplier, they must enroll with National Supplier Clearinghouse and bill the DMERC. However, the DMERC will not separately pay for items of DME provided to a beneficiary in a Part A SNF stay.

Those items or services that are considered outside the PPS rate may be billed by the supplier in the case of a SNF or hospital to the intermediary, or if furnished by a qualified outside entity, that entity may bill its normal contractor.

The SNFs, hospitals, or other entities that furnish prosthetic and/or orthotic devices to their patients for whom Part A benefits are not payable (i.e., no Part A entitlement or benefits exhausted) may bill for such items, assuming other billing requirements are met.

NOTE: Items such as catheters and ostomy supplies are excluded from the fee schedule when billed by HHAs for patients under a plan of care. In this situation, HHAs bill for these items as supplies under revenue code 270. Effective with items furnished on or after January 1, 1994, the fee schedules for ostomy, tracheostomy, and urological supplies are calculated using the same method used to calculate the purchase fee schedules for inexpensive or other routinely purchased DME.

HCPCS codes A4214, A4310 through A4330, A4338 through A4359, and A5102 through A5114 are excluded from the fee schedule when billed by hospitals along with an ASC service. Hospitals bill for these items as supplies, under revenue code 272. In addition, HCPCS codes A5119 through A5131 are excluded from the fee schedule unless they are submitted with ostomy related ASC procedure codes 44340 through 44346, 44380, 44382, 44388 through 44392, or 50953 through 50961.

In all other circumstances, including HHAs billing for patients not under a plan of care, SNFs, CORFs, OPTs, and hospitals bill these items as prosthetics and orthotics under revenue code 274, along with the relevant HCPCS code.

130.2 - Billing for Inexpensive or Other Routinely Purchased DME

(Rev.)

A3-3629, B3-4107.8

This is equipment with a purchase price not exceeding $150, or equipment that the Secretary determines is acquired by purchase at least 75 percent of the time, or equipment that is an accessory used in conjunction with a nebulizer, aspirator, or ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices. Suppliers and providers other than HHAs bill the DMERC or, in the case of implanted DME only, the local carrier. HHAs bill the RHHI.

Effective for items and services furnished after January 1, 1991, Medicare DME does not include seat lift chairs. Only the seat lift mechanism is defined under Medicare as DME. Therefore, seat lift coverage is limited to the seat lift mechanism. If a seat lift chair is provided to a beneficiary, contractors only pay for the lift mechanism portion of the chair. Some lift mechanisms are equipped with a seat that is considered an integral part of the lift mechanism. Contractors do not pay for chairs (HCPCS code E0620) furnished on or after January 1, 1991. The appropriate HCPCS codes for seat lift mechanisms are E0627, E0628, and E0629.

For TENS, suppliers and providers other than HHAs bill the DMERC. HHAs bill the RHHI using revenue code 291 for the 2-month rental period (see §30.1.2), billing each month as a separate line item and revenue code 292 for the actual purchase along with the appropriate HCPCS code**.**

130.3 - Billing for Items Requiring Frequent and Substantial Servicing

(Rev.)

A3-3629, B3-4107.8

These are items such as intermittent positive pressure breathing (IPPB) machines and ventilators, excluding ventilators that are either continuous airway pressure devices or intermittent assist devices with continuous airway pressure devices.

Suppliers and providers other than HHAs bill the DMERC. HHAs bill the RHHI.

130.4 - Billing for Certain Customized Items

(Rev.)

A3-3629, B3-4107.8

Due to their unique nature (custom fabrication, etc.), certain customized DME cannot be grouped together for profiling purposes. Claims for customized items that do not have specific HCPCS codes are coded as E1399 (miscellaneous DME). This includes circumstances where an item that has a HCPCS code is modified to the extent that neither the original terminology nor the terminology of another HCPCS code accurately describes the modified item.

Suppliers and providers other than HHAs bill the DMERC or local carrier. HHAs bill their RHHI, using revenue code 292 along with the HCPCS.

130.5 - Billing for Capped Rental Items (Other Items of DME)

(Rev.)

A3-3629, B3-4107.8

These are DME items, other than oxygen and oxygen equipment, not covered by the above categories. Suppliers and providers other than HHAs bill the DMERC. HHAs bill the RHHIs.

130.6 - Billing for Oxygen and Oxygen Equipment

(Rev.)

B3-4107.7, A3-3629

The following instructions apply to all claims from providers and suppliers to whom payment may be made for oxygen**.** The chart in §130.6.1 indicates what is payable under which situation.

A - Monthly Billing

Fee schedule payments for stationary oxygen system rentals are all inclusive and represent a monthly allowance per beneficiary. Accordingly, a supplier must bill on a monthly basis for stationary oxygen equipment and contents furnished during a rental month.

A portable equipment add-on is also payable when portable oxygen is prescribed and it is determined to be medically necessary in accordance with Medicare coverage requirements. The portable add-on must be claimed in order to be paid. (See §30.6.)

Claims may be submitted to the contractor when expenses are incurred for initial rentals of oxygen systems or, no sooner than the monthly anniversary date in the case of an established oxygen patient. In the latter situation, suppliers must indicate the monthly volume of oxygen contents delivered, rounded in accordance with CMS specifications

Where the beneficiary has purchased a stationary system (other than a concentrator and/or a portable delivery system), oxygen contents must be billed and paid on a monthly basis, except for unassigned oxygen contents claims submitted by a beneficiary. For beneficiary filed claims, carriers allow, on a claim-by-claim basis, the submitted charge until the applicable monthly fee for oxygen contents has been met.

B - HCPCS Codes

HCPCS codes must be used to report the service.

C - Use of Payment Modifiers and Revenue Codes for Payment Adjustments

The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed (liters per minute (LPM)), and whether or not portable oxygen is also prescribed. (See §§30.6.) HHAs billing the intermediary for stationary equipment, supplies, or contents, which are not eligible for payment adjustment, bill under revenue code 601. Claims must indicate the appropriate HCPCS modifier described below, if applicable.

- If the prescribed amount of oxygen is less than 1 LPM, suppliers use the modifier "QE"; HHAs use revenue code 602. The monthly payment amount for stationary oxygen is reduced by 50 percent.

- If the prescribed amount of oxygen is greater than 4 LPM, suppliers use the modifier "QG"; HHAs use revenue code 603. The monthly payment amount for stationary oxygen is reduced by 50 percent.

- If the prescribed amount of oxygen exceeds 4 LPM and portable oxygen is prescribed, suppliers use the modifier "QF"; HHAs use revenue code 604. The monthly payment for stationary oxygen is increased by the higher of 50 percent of the monthly stationary oxygen payment amount, **or,** the fee schedule amount for the portable oxygen add-on. (A separate monthly payment is not allowed for the portable equipment.)

D - Units Required

Excluding concentrators, suppliers must furnish units of oxygen contents claimed, or the itemized bill furnished to the beneficiary for unassigned claims.

1. Initial Oxygen Claims

When submitting an initial claim for rental of a gaseous or liquid oxygen delivery system, units of oxygen contents furnished for the first month need not be indicated. Payment is based upon the lower of the actual charge for the initial rental month or the monthly payment amount.

2. Subsequent Oxygen Claims

For dates of service subsequent to the initial rental month, suppliers should indicate actual content usage for the month billed or, if billed prospectively, the actual content usage during the previous rental month, rounded in accordance with subsection D.3. Payment determination is based on the lower of the actual charge submitted or the monthly payment amount.

For applying these instructions, contractors treat claims submitted under recertifications of continuing and uninterrupted need for oxygen therapy as subsequent claims if a change in suppliers is not involved.

If a change in suppliers has occurred, contractors apply the initial rule in subsection D.1 above for specifying oxygen contents delivered for the initial rental month by the new supplier.

Contractors develop subsequent rental claims for gaseous or liquid oxygen delivery systems that do not include "unit" information.

3. Rounding of Oxygen Contents

For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen was delivered during the rental month, unit entry "01" indicates the nearest 50 cubic foot increment. For stationary liquid systems, units of contents

should be specified in multiplies of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is made. For units of portable contents only (i.e., no stationary gas or liquid system used), suppliers round to the nearest five cubic feet or one liquid pound, respectively.

E - Conserving Device Modifier

HHA's and suppliers must indicate if an oxygen conserving device is being used with an oxygen delivery system by using HCPCS modifier "QH".

130.6.1 - Oxygen Equipment and Contents Billing Chart

(Rev.)

The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios for providers and suppliers:

1. Situation: Beneficiary Uses a Stationary System Only

    a. Rental Cases (Beneficiary Uses a Stationary System Only)

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	Yes	No	No	No
	E1377 E1378 E1379 E1380 E1381 E1382 E1383 E1384 E1385 E1400 E1401 E1402 E1403 E1404 E1405 E1406			
Gaseous	Yes	No	No	No
	E0424			

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Liquid	Yes	No	No	No
	E0439			

b. Purchase Cases (Beneficiary Uses a Stationary System Only)

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	No	No	No	No
Gaseous	No	Yes	No	No
		E0441		
Liquid	No	Yes	No	No
		E0442		

2. Situation: Beneficiary Uses Both a Stationary and Portable System

a. Rents Stationary/Rents Portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	Yes	No	Yes	No
	E1377 E1378 E1379 E1380 E1381 E1382 E1383 E1384 E1385 E1400		E0431 E0434	

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
	E1401 E1402 E1403 E1404 E1405 E1406			
Gaseous	Yes	No	Yes	No
	E0424		E0431	
Liquid	Yes	No	Yes	No
	E0439		E0434	

b. Rents Stationary/Owns Portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	Yes	No	No	No
	E1377 E1378 E1379 E1380 E1381 E1382 E1383 E1384 E1385 E1400 E1401 E1402 E1403 E1404 E1405 E1406			
Gaseous	Yes	No	No	No

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
	E0424			
Liquid	Yes	No	No	No
	E0439			

c. Owns Stationary/Owns Portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	No	No	No	Yes
				E0443 E0444
Gaseous	No	Yes	No	No
		E0441		
Liquid	No	Yes	No	No
		E0442		

d. Owns Stationary/Rents Portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee
Concentrator	No	No	Yes	Yes
			E0431 E0434	E0443 E0444
Gaseous	No	Yes	Yes	No
		E0441	E0431	
Liquid	No	Yes	Yes	No
		E0442	E0434	

3. Situation: Beneficiary Uses a Portable System Only

a. Rents Portable System (Beneficiary Uses a Portable System Only)

Type of System	**Stationary Monthly Payment**	**Oxygen Content Fee**	**Portable Add-On**	**Portable Contents Fee**
Gaseous	No	No	Yes	Yes
			E0431	E0443
Liquid	No	No	Yes	Yes
			E0434	E0444

b. Owns Portable System (Beneficiary Uses a Portable System Only)

Type of System	**Stationary Monthly Payment**	**Oxygen Content Fee**	**Portable Add-On**	**Portable Contents Fee**
Gaseous	No	No	No	Yes
				E0443
Liquid	No	No	No	Yes
				E0444

NOTE: For HHAs revenue codes 601, 602, 603, and 604 may apply when billing for oxygen under the situations in this chart

130.7 - Billing for Maintenance and Servicing (Providers and Suppliers)

(Rev.)

A3-3629

General

Payment is not made for maintenance and servicing if the beneficiary rents the equipment since payment for maintenance and servicing are included in the rental payments. An exception to this is the 6-month service fee for capped rental items that the beneficiary has elected not to purchase (see §40.2 and 130.5).

Where purchase is permitted (including "Capped Rental Items" **and** where the beneficiary elects to purchase), payment for reasonable and necessary maintenance and servicing is made for such purchased equipment.

Coding to Identify Maintenance an Servicing

Capped Rental

If the service is capped rental, suppliers that bill the DMERC for the maintenance and servicing fee (see §40.2) use modifier -MS with the HCPCS code for the equipment to show that parts and labor which are not covered under any manufacturer or supplier warranty.

HHAs that bill the intermediary for maintenance and servicing of capped rental items use revenue code 299 along with the appropriate HCPCS code for the equipment.

Not Capped Rental

Suppliers that bill the DMERCs for maintenance and servicing indicate the HCPCS code of the item serviced and the modifier –RP, replacement or repair.

HHAs that bill intermediaries for maintenance and servicing use revenue code 299 and the appropriate HCPCS code for the equipment serviced.

Hospitals report revenue code 274 along with one of the following HCPCS codes: L4205, L4210, L7500, L7510, or L7520 when billing the intermediary for maintenance and servicing of prosthetics and orthotics.

130.8 - Installment Payments

(Rev.)

A3-3629

Where a beneficiary is purchasing an item through installments, the total price of the equipment item is reported on the first bill. Monthly payments are made (by the DMERC, carrier, intermediary or RHHI). The monthly amount is equivalent to the rental fee schedule amount and is paid until the fee schedule purchase price or actual charge has been reached, whichever comes first.

130.9 - Showing Whether Rented or Purchased

(Rev.)

Claims must specify whether equipment is rented or purchased. For purchased equipment, the itemized bill or claim must also indicate whether equipment is new or used. If the provider or supplier fails to indicate on an assigned claim whether equipment was new or used, the contractor processing the claims assumes purchased equipment is used and process the claim accordingly, i.e., they pay on the basis of the used purchase fee. If an unassigned purchase claim does not specify whether the item was new or used, contractors develop the claim with the supplier. The following table indicates the HCPCS modifiers which are added to the equipment code to indicate its status:

-BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
-BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
-BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
-KH	DMEPOS item, initial claim, purchase or first month rental
-KI	DMEPOS item, second or third month rental
-KJ	DMEPOS item, PEN pump or capped rental months four to fifteen
-NR	New when rented (use the 'NR' modifier when an item that was new at the time of rental is subsequently purchased)
-NU	New equipment
-RR	Rental (use the 'RR' modifier when DME is to be rented)

-UE	Used durable medical equipment

HHAs report the appropriate modifier in FL 44 of the CMS-1450, or electronic equivalents, following the appropriate HCPCS code. RHHIs accept 7 positions in this field for data entry purposes.

140 - Billing for Supplies

(Rev.)

140.1 - Billing for Supplies and Drugs Related to the Effective Use of DME

(Rev.)

A3-3629

Suppliers and providers bill supplies that are necessary for the effective use of DME, including drugs, with the appropriate HCPCS code identifying the supply. HHAs must also report revenue code 294, "Supplies/Drugs for DME Effectiveness."

Suppliers and providers, other than HHAs, bill supplies and drugs (not including drugs that are necessary for the effective use of implanted DME) that are necessary for the effective use of DME to the DMERCs. HHAs bill the RHHIs.

Suppliers and providers, other than HHAs, bill for drugs that are necessary for the effective use of implanted DME (HCPCS codes E0751, E0753, E0782, and E0783) to the local carrier. HHAs bill the RHHIs.

RHHIs contact the DMERC or local carrier as necessary to determine drug prices.

140.2 - Billing for HHA Medical Supplies

(Rev.)

HHA-206.4, HHA-219.1, HHA-461 (partial), HO-228.3, SNF-260.3

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling personnel to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Medical supplies fit into two categories. They are classified as:

- Routine because they are used in small quantities for patients during the usual course of most home visits; or

- Nonroutine because they are needed to treat a patient's specific illness or injury in accordance with the physician's plan of care and meet further conditions discussed in more detail below.

Both routine and non-routine medical supplies are included in the home health PPS rate and are not separately payable if the beneficiary is under a home health plan of care. CMS publishes a list of these medical supplies annually, identified by HCPCS code. If no home health plan of care is in place, non-routine medical supplies are reported separately on the bill and the supplies are payable on 34x bills.

140.3 - Billing DMERC for Home Dialysis Supplies and Equipment

(Rev.)

B3-3045.7

See Chapter 8 for claims processing instructions for Method II for suppliers and DMERCs.

150 - Institutional Provider Reporting of Service Units for DME and Supplies

(Rev.)

A3-3629

Provider outpatient departments report under FL 46 "Service Units," (Form CMS 1450 or electronic equivalent) the number of items being billed for orthotic and prosthetic devices.

For purchased DMEPOS items (excluding items requiring frequent and substantial servicing, capped rental items, and oxygen which cannot be purchased) HHAs report under FL 46 "Service Units," the number of purchased items billed. For rental DME items, including oxygen equipment, HHAs report a separate line for each month billed indicating "1" in FL 46.

For oxygen contents (HCPCS codes E0441, E0442, E0443, and E0444), the HHAs report the number of feet or pounds as described by the HCPCS code.

160 - Billing for Total Parenteral Nutrition and Enteral Nutrition

(Rev.)

A3-3660.6

All providers and suppliers billing for parenteral and enteral nutrition covered as a Part B prosthetic device benefit bill the DMERCs. Medicare pays for no more than a one-month

supply of parenteral or enteral nutrients for any one prospective billing period. Claims submitted retroactively may include multiple months.

160.1 - Billing for Total Parenteral Nutrition and Enteral Nutrition Furnished to Part B Inpatients

(Rev.)

A3-3660.6, SNF-544, SNF-559, SNF-260.4, SNF-261, HHA-403, HO-438, HO-229

Inpatient Part A hospital or SNF care includes total parenteral nutrition (TPN) systems and enteral nutrition (EN).

For inpatients for whom Part A benefits are not payable (e.g., benefits are exhausted or the beneficiary is entitled to Part B only), total parenteral nutrition (TPN) systems and enteral nutrition (EN) delivery systems are covered by Medicare as prosthetic devices when the coverage criteria are met. When these criteria are met, the medical equipment and medical supplies (together with nutrients) being used comprise covered prosthetic devices for coverage purposes rather than durable medical equipment. However, reimbursement rules relating to DME continue to apply to such items.

When a facility supplies TPN or EN systems that meet the criteria for coverage as a prosthetic device to an inpatient whose care is not covered under Part A, the facility must bill one of the DMERCs. Additionally, HHAs, SNFs, and hospitals that provide PEN supplies, equipment and nutrients as a prosthetic device under Part B must use the CMS-1500 or the related NSF or ANSI ASC X12N 837 format to bill the appropriate DMERC. The DMERC is determined according to the residence of the beneficiary. Refer to §10 for jurisdiction descriptions.

Intermediaries return claims containing PEN charges for Part B services where the bill type is 12x, 13x, 22x, 23x, 32x, 33x, or 34x with instructions to the provider to bill the DMERC.

160.2 - Special Considerations for SNF Billing for TPN and EN Under Part B

(Rev.)

SNF-368, SNF-559, A3-3660.6

The HCPCS code and any appropriate modifiers are required.

Instructions in the Medicare Claims Processing Manual Chapter 26, Billing Formats, for the 1500 related formats are applicable.

The following HCPCS codes apply.

B4034 B4035 B4036 B4081 B4082 B4083 B4084 B4085 B4150 B4151 B4152 B4153 B4154 B4155 B4156 B4164 B4168 B4172 B4176 B4178 B4180 B4184 B4186 B4189 B4193 B4197 B4199 B4216 B4220 B4222 B4224 B5000 B5100 B5200 B9000 B9002 B9004 B9006 E0776XA B9098 B9099

For SNF billing for PEN, a SNF includes the charges for PEN items it supplies beneficiaries under Part A on its Part A bill. The services of SNF personnel who administer the PEN therapy are considered routine and are included in the basic Part A payment for a covered stay. SNF personnel costs to administer PEN therapy are not covered under the Part B prosthetic device benefit.

If TPN supplies, equipment and nutrients qualify as a prosthetic device and the stay is not covered by Part A, they are covered by Part B. Part B coverage applies regardless of whether the TPN items were furnished by the SNF or an outside supplier. The Part B TPN bill must be sent to the DME regional carrier regardless of whether supplied by the SNF or an outside supplier.

Enteral nutrients provided during a stay that is covered by Part A are classified as food and included in the routine Part A payment sent to the SNF. (See Provider Reimbursement Manual, §2203.1E.) Parenteral nutrient solutions provided during a covered Part A SNF stay are classified as intravenous drugs. The SNF must bill these services as ancillary charges. (See Provider Reimbursement Manual, §2203.2.)

170 - Billing for Splints and Casts

(Rev.)

AB-01-60, AB-01-126

The cost of supplies used in creating casts are not included in the payment amounts for the CPT codes for fracture management and for casts and splints. Thus, for settings in which CPT codes are used to pay for services that include the provision of a cast or splint, supplies maybe billed with separate CPCS codes. The work and practice expenses involved with the creation of the cast or splint are included in the payment for the code for that service**.**

For claims with dates of service on or after July 1, 2001, jurisdiction for processing claims for splints transferred from the DMERCs to the local carriers. The local carriers have jurisdiction for processing claims for splints and casts, which includes codes for splints that may have previously been billed to the DMERCs.

Jurisdiction for slings is jointly maintained by the local carriers (for physician claims) and the DMERCs (for supplier claims). Notwithstanding the above where the beneficiary receives the service from any of the following providers claims jurisdiction is with the intermediary. An exception to this is hospital outpatient services and hospital inpatient Part B services, which are included in the OPPS payment and are billed on the Form CMS-1450 to the intermediary.

Other providers and suppliers that normally bill the intermediary for services bill the carrier for splints and casts.

190 - Contractor Application of Fee Schedule and Determination of Payments and Patient Liability for DME Claims

(Rev.)

A3-3629, B3-5102

The following instructions apply to all contractors processing DMEPOS claims:

First the 'allowable amount' is determined. This is the lower of the fee schedule amount or the billed charge.

The application of deductible and coinsurance are calculated as follows.

A - Claims to Carriers and DMERC

Any unmet deductible is subtracted from the allowed amount and 80 percent of the remainder is paid.

B - Claims to Intermediaries

NOTE: Per 42 CFR 410.2, a nominal charge provider means a provider that furnishes services free of charge or at a nominal charge, and is either a public provider or another provider that (1) demonstrates to CMS's satisfaction that a significant portion of its patients are low-income; and (2) requests that payment for its services be determined accordingly.

1. Payment to a Provider Other Than Nominal Charge Provider

To determine the Part B payment to a provider other than nominal charge provider, FIs and RHHIs subtract any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiply the remainder by 80 percent. This is the final payment. (If the item or service is furnished by a HHA and is covered under a plan of care, the payment is determined in the same way, except that no deductible is applicable.)

2. Payment to a Nominal Charge HHA

To determine the Part B payment to a nominal charge HHA, RHHIs subtract any unmet Part B deductible from the fee schedule amount and multiply the remainder by 80 percent. This is the final payment. (If the item or service is covered under a plan of care, the payment is determined in the same way, except that no deductible is applicable.) For these items and services, no providers other than HHAs are considered nominal charge providers.

3. Payment to a Nominal Charge Provider Other Than a Nominal Charge HHA

To determine the Part B payment to a nominal charge provider other than a nominal charge HHA, FIs subtract any unmet Part B deductible from the lower of the actual charge or the fee schedule amount and multiply the remainder by 80 percent. This is the final payment.

4. Patient Liability to a HHA Other Than a Nominal Charge HHA

To determine the patient liability to a HHA other than a nominal charge HHA under Part B, RHHIs subtract any unmet deductible from the lower of the actual charge or fee schedule amount and multiply the remainder by 20 percent. The result, plus the unmet deductible is the patient's liability. If the item or service is covered under a plan of care, the deductible does not apply.

5. Patient Liability to a Nominal Charge HHA

To determine patient liability to a nominal charge HHA under Part B, RHHIs subtract any unmet deductible from the fee schedule amount and multiply the remainder by 20 percent. The result, plus the unmet deductible is the patient's liability. If the item or service is covered under a Plan of Care, the deductible does not apply.

6. Patient Liability to a Provider Other Than a HHA

To determine patient liability to a provider other than a HHA (including nominal charge providers other than a HHA), FIs subtract any unmet deductible from the actual charge and multiply the remainder by 20 percent. The result, plus the unmet deductible is the patient's liability. Coinsurance is applied as applicable.

The following describes application of deductible and coinsurance on HHA bills by bill type:

a. Patient Under Part B Plan of Treatment (Bill Type 32X)

- No deductible applicable; and
- No coinsurance applicable

Exception: Coinsurance applies on DME and orthotic/prosthetic claims.

b. Patient Under Part A Plan of Treatment (Bill Type 33X)

- No deductible applicable; and
- No coinsurance applicable

Exception: Coinsurance applies on DME and orthotic/prosthetic claims.

c. Patient Not Under Plan of Treatment, Part B Medical and Other Health Services and Osteoporosis Injections (Bill Type 34X)

- Deductible applies; and
- Coinsurance applies

The following examples illustrate how to calculate provider payment and patient liability in various situations. The examples like the proceeding rules for HHAs address items and services not under a Plan of Care and, therefore, include deductible application. The Note following each HHA example addresses items and services obtained under a Plan of Care and, therefore, do not address deductible application.

Example 1: CLAIM CONTAINING ONLY ORTHOTIC/PROSTHETIC CHARGES

$200.00 Orthotic/prosthetic charges

$140.00 Orthotic/prosthetic fee schedule amount

$100.00 Part B deductible to be met

To determine the payment to all providers (other than nominal charge HHAs) apply the following steps:

Step 1: Determine the lower of the actual charge or the fee schedule amount: $140.00 (do not apply the provider's interim rate)

Step 2: Subtract any unmet Part B deductible from the amount determined in Step 1: $140.00 - $100.00 = $40.00

Step 3: Apply 80% to the amount determined in Step 2: $40.00 X 80% = $32.00

The Part B payment to the provider in this example is $32.00.

To determine payment to nominal charge HHAs apply the following steps:

Step 1: Subtract any unmet deductible from the fee schedule amount: $140.00 - $100.00 = $40.00

Step 2: Apply 80% to the amount determined in Step 1: $40.00 x 80% = $32.00

The Part B payment to the nominal charge HHA in this example is $32.00

NOTE: If the item or service is covered under a Home Health Plan of Care, the payment is determined the same way, except no deductible is applicable. In the above examples the payment would be $112.00 ($140.00 x 80%).

To determine beneficiary liability to providers other than HHAs apply the following steps:

Step 1: Subtract any unmet Part B deductible from the actual charge: $200.00 - $100.00 = $100.00

Step 2: Multiply the amount determined in Step 1 by 20% coinsurance: $100.00 x 20% = $20.00

Step 3: Add the result of Step 2 to the unmet deductible: $20.00 + $100.00 = $120.00

The beneficiary's liability in this example is $120.00. ($100.00 Part B deductible and $20.00 coinsurance.)

To determine beneficiary liability to HHAs (other than nominal charge) apply the following steps:

Step 1: Subtract any unmet deductible from the lower of the actual charge or the fee schedule amount: $140.00 - $100.00 = $40.00

Step 2: Multiply the amount determined in Step 1 by 20% coinsurance: $40.00 X 20% = $8.00

Step 3: Add the result of Step 2 to the unmet deductible: $8.00 + $100.00 = $108.00

The beneficiary's liability in this example is $108.00 ($100.00 Part B deductible an $8.00 coinsurance.)

NOTE: If the item or service is covered under a Home Health Plan of Care, the beneficiary's liability is determined the same way, except no deductible is applicable. In this example the beneficiary's liability would be $28.00 ($140.00 x 20% coinsurance).

To determine beneficiary liability to nominal charge HHAs apply the following steps:

Step 1: Subtract any unmet Part B deductible from the fee schedule amount: $140.00 - $100.00 = $40.00

Step 2: Multiply the amount determined in Step 1 by 20% coinsurance: $40.00 x 20% = $8.00

Step 3: Add the result of Step 2 to the unmet deductible: $8.00 + $100.00 = $108.00

The beneficiary's liability in this example is $108.00 ($100.00 Part B deductible and $8.00 coinsurance).

NOTE: If the item of service is covered under a Home Health Plan of Care, the beneficiary's liability is determined the same way, except no deductible is applicable. In this example, the beneficiary's liability would be $28.00 ($140.00 x 20% coinsurance).

Example 2: CLAIM CONTAINING ONLY ORTHOTIC/PROSTHETIC CHARGES - NEGATIVE PAYMENT

$120.00 Orthotic/prosthetic charges

$ 80.00 Orthotic/prosthetic fee schedule amount

$100.00 Part B deductible to be met

To determine the payment to all providers (other than nominal charge HHAs) apply the following steps:

Step 1: Determine the lower of the actual charge or the fee schedule amount: $80.00 (do not apply the provider's interim rate)

Step 2: Subtract any unmet Part B deductible from amount determined in Step 1: $80.00 - $100.00 = -$20.00

Do not apply the 80 percent since the result of Step 2 is a negative amount. There is no Part B payment to the provider in this example because the result equals a negative payment amount. FIs do not take the negative amount of (-$20.00) from future payments to the provider.

To determine payment to nominal charge HHAs, apply the following step:

Step 1: Subtract any unmet deductible from the fee schedule amount: $80.00 - $100.00 = -$20.00

Do not apply the 80 percent since the result of Step 1 is a negative amount. There is no Part B payment to the nominal charge HHA in this example because the result equals a negative payment amount. RHHIs do not take the negative amount of (-$20.00) from future payments to the HHA.

NOTE: If the item or service is covered under a Home Health Plan of Care the payment is determined in the same way, except no deductible is applicable. In the above examples the payment would be $64.00 ($80.00 x 80%).

To determine beneficiary liability to providers other than HHAs, apply the following steps:

Step 1: Subtract any unmet Part B deductible from the actual charge: $120.00 - $100.00 = $20.00

Step 2: Multiply the amount in Step 1 by 20% coinsurance: $20.00 x 20% = $4.00

$4.00

The beneficiary's liability in this example is $104.00 ($100.00 Part B deductible and $4.00 coinsurance).

The beneficiary's liability to HHAs (nominal charge and other than nominal charge) in this example is $80.00 (the fee schedule amount for nominal charge HHAs or the lower of the fee schedule amount or the actual charge for other than nominal charge HHAs). The HHA cannot charge the beneficiary the $100.00 deductible since it exceeds $80.00. $80.00 is credited to the beneficiary's deductible. The beneficiary's deductible to be met on the next claim is $20.00. The beneficiary has no coinsurance obligation.

NOTE: If the item or service is covered under a Home Health Plan of Care, the beneficiary's liability is determined the same way, except that no deductible is applicable. The beneficiary's liability in this example would be $16.00 coinsurance ($80.00 x 20%).

200 - Automatic Mailing/Delivery of DMEPOS

(Rev.)

Suppliers/manufacturers **may not** automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has **requested** additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS. Contractor review should be done on a post-pay basis.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. A supplier may not initiate a refill of an order. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. This is consistent with the DMERC Supplier Manual, which states: "The description of the item (on an order) may be completed by someone other than the physician (most commonly the supplier). However, the physician must review the order and sign and date it to indicate agreement." Again the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

DMERCs inform suppliers of these procedures via their bulletins and training sessions. These procedures will benefit suppliers by helping to maximize claims processing accuracy, and to reduce the likelihood of a postpayment claim denial because the DMEPOS were not medically necessary.

DMERCs must publish this information on their Web sites and in their bulletins on an annual basis.

210 - Appeals

(Rev.)

See Chapter 29 for a description of the appeals process.