

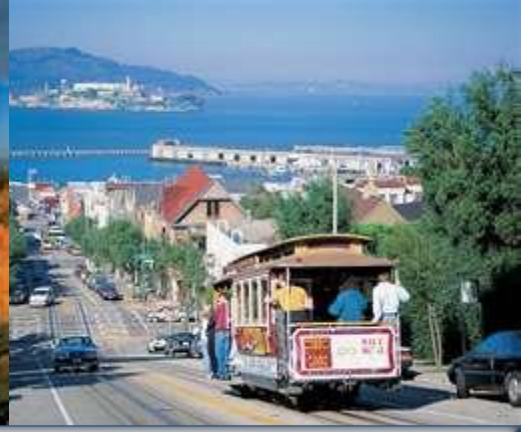


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5/2017

Acronyms

ADMC Advance determination of Medicare coverage
ABN Advance Beneficiary Notice of Non Coverage
ADR Additional Documentation Request
CMS Centers for Medicare & Medicaid Services
CBA Competitive Bidding Area
CBIC Competitive Bid Implementation Contractor
DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
IRMAA Income-Related Monthly Adjustment Amount
MAC Medicare Administrative Contractor
WOPD Written Order Prior to Delivery

- An agency of Health and Human Services
- **An Insurance Program** that oversees
  - Medicare (May 2015 over 71 million beneficiaries)
  - Medicaid (2015 over 60 million beneficiaries)
  - Children's Health Insurance Program (CHIP) (2015 over 7 million beneficiaries)
  - Health Insurance Marketplace (over 8 million consumers)

Medicaid and CHIP cover nearly 1 in 5 people in the country in 2015

Medicare Beneficiaries as a Percent of Total Population 2015

Data include aged and/or disabled individuals enrolled in Medicare Part A and/or B through Original Medicare or Medicare Advantage and Other Health Plans during the calendar year specified. Medicare enrollment is based on CMS administrative enrollment data and are calculated using a person-year methodology.

Location	Medicare Beneficiaries as a Share of Total Population
Arizona	17%
Arkansas	20%
California	14%

http://kff.org/medicare/

Medicare Program Responsibilities

- Medicare ***oversees*** the Medicare program

- Social Security ***administers*** the Medicare program
  - Enrollment
  - Collect payments

CMS Responsibilities (cont'd)

- Contractors process over one billion Medicare claims annually

- Provide the States with matching funds for Medicaid benefits

- Assure the safety and quality of medical facilities
  - Quality standards - survey & certification (S&C)
  - Clinical Laboratory Improvement Amendments (CLIA)
  - Quality Improvement Organizations (QIO)

CMS Responsibilities (cont'd)

- Determine how to best meet beneficiary needs and improve health outcomes through the most cost-effective manner

  - Innovation Center
    - ACO (Accountable Care Organization)
    - Prior Approval – models
      Ambulance, HHA
    - Pre-approval of non-urgent ambulance

  - Grants to stimulate innovation
    - Decrease hospital readmission

  - Create new payment models
    - DRG
    - PPS

What are the Four Parts of Medicare?

Part A

Hospital Insurance

SNF

HHA

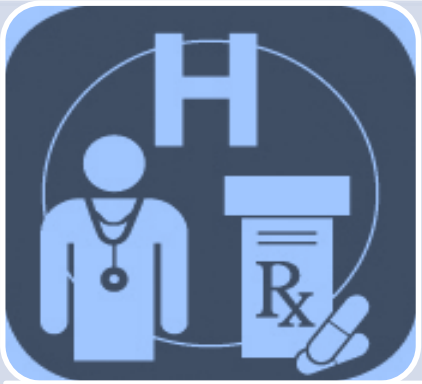
Hospice

Part B

Medical Insurance

Outpatient

DME



Part C

Medicare Advantage Plans , like HMOs and PPOs

Includes Part A & B and usually Part D coverage

Part D

Medicare Prescription Drug Coverage

Original Medicare - FFS

Part A – Hospital Insurance - Medical necessity

Skilled Nursing Facility - SNF

Does not cover custodial or long-term care

Home health care – must meet homebound criteria

Hospice care - Terminal diagnosis within 6 mths

Part B Covered Preventive Services

includes the following, *usually without cost to the beneficiary*

- "Welcome to Medicare" visit
- Annual "Wellness" visit
- Abdominal aortic aneurysm screening*
- Alcohol misuse screening and counseling
- Behavioral therapy for cardiovascular disease
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Diabetes self-management training
- Flu shots
- Glaucoma tests
- Hepatitis B vaccine
- HIV screening
- Mammograms (screening)
- Obesity screening and counseling
- Pap test/pelvic exam/clinical breast exam
- Pneumococcal pneumonia vaccine
- Prostate cancer screening
- Sexually transmitted infection screening (STIs) and high-intensity behavioral counseling to prevent STIs
- Smoking cessation

*When referred during Welcome to Medicare physical exam

NOT Covered by Part A or Part B

- Long-term or custodial care
  - Chronic care, housing
- Routine dental care
- Dentures
- Cosmetic surgery
- Acupuncture
- Routine vision care
- Hearing aids & exams for fitting hearing aids

Part A late enrollment penalty

- If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%.
  - You'll have to pay the higher premium for twice the number of years you could have had Part A, but didn't sign up.
  - Example:
    - If you were eligible for Part A for 2 years but didn't sign up, you'll have to pay the higher premium for 4 years.
    - Usually, you don't have to pay a penalty if you meet certain conditions that allow you to sign up for Part A during a special enrollment period.

Part B late enrollment penalty

- Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it.

- You may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B, and coverage will start July 1 of that year.

- You'll have to pay this penalty for as long as you have Part B.

Part B late enrollment – Credible coverage

Credible coverage

- Usually, you don't pay a late enrollment penalty if you meet certain conditions that allow you to sign up for Part B during a Special Enrollment Period.

- **Don't go 63 days or more in a row without a Medicare drug plan or other creditable drug coverage.**

- Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or health insurance coverage.

IRMAA

*Income-**R**elated **M**onthly **A**djustment **A**mount*

- The Affordable Care Act requires **high-income** seniors to pay more for their Part B Premium and Part D premium.

- Applies to tax returns show more than:

  individuals - $85,000 of income

  joint return - $170,000

- IRMAA is adjusted each year, as it is calculated from the annual beneficiary base premium

Medigap Policies

- Medigap (Medicare Supplement) Insurance policies
  - Sold by private insurance companies
  - Supplement Original Medicare coverage
  - CMS mandates the benefit structure
  - Regulated by the states

- Medigap Guaranteed Issue Period (6 months)
  - Starts when you are both 65 and sign up for Part B
  - Once started cannot be delayed or repeated

Medigap Guaranteed Issue Period

No later than 63 calendar days after the latest of these 3 dates:

- Date the coverage ends
- Date on the notice you get telling you that coverage is ending (if you get one)
- Date on a claim denial, if this is the only way you know that your coverage ended

See additional rules:

https://www.medicare.gov/find-a-plan/staticpages/learn/rights-and-protections.aspx

Medigap Policies, cont.

- There is a sizeable monthly premium
- Premium varies by plan, company, and location
  - Helps pay for “gaps” in Original Medicare coverage - like deductibles, coinsurance, and copayments
  - May cover certain things Medicare doesn’t depending on the Medigap plan
- Standardized benefit design means that policies offered by different companies have identical benefits
- Private health insurance that cover only the policy holder, not the spouse
- *Does not work with Medicare Advantage*

Medigap Policies, cont.

- Medigap insurance companies can only sell "standardized" Medigap policies that are Identified in most states by letters.

- Medigap policies have no networks except with a **Medicare SELECT** policy.

  – Medicare SELECT: must use specified provider network

- You pay a monthly premium for a Medigap policy to the insurance company that sells it.

Help for Low Income People

- Low Income Subsidy or “Extra Help”
  - Pays premium up to a benchmark
  - Lowers copayments
  - No Coverage Gap or “donut hole”

- Medicare Savings Program
  - Medicaid can pay the Medicare Part B premium
  - Medicaid pays for Part A in some cases

ABN
Advance Beneficiary Notice of Non Coverage

➢ Purpose of ABN

- The ABN of Non Coverage will be used to notify you ahead of time that Medicare will probably not pay for a certain item or service in a specific situation, even if Medicare might pay under different circumstances. The form should be detailed enough that you understand why Medicare will probably not pay for the item you are requesting.

- Allows you to make an informed decision about whether or not to receive the item or service knowing that you may have additional out-of-pocket expenses.

Mandatory ABN

- Services always denied for medical necessity
- Frequency limited items
- Denial of advance determination of Medicare coverage (ADMC)
- Certain instances of upgrades
- No Medicare supplier number
- Unsolicited telephone contact made by supplier
- Noncontract supplier furnishing DMEPOS in competitive bid area (effective 9/4/12)

No ABN Required If…

Some examples of non-covered services:

- Ambulance for non-emergency
- Plastic Surgery
- Acupuncture
- Eye examinations related to prescribing glasses
- Routine hearing exams, hearing aids, or exams for fitting hearing aids

Voluntary ABN

- Does not meet the definition of a Medicare benefit
  - Parenteral/enteral nutrients to treat temporary condition or are administered orally
  - Infusion drugs not administered through infusion pump
  - Surgical dressings used to clean wounds or intact skin or provide protection to intact skin
  - Irrigation supplies used to irrigate skin or wounds
  - Immunosuppressive drugs used for conditions other than following organ transplants

Beneficiary Notices Initiative (BNI)

Medicare Outpatient Observation Notice (MOON)

- The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving **observation services** and are not inpatients of a hospital or critical access hospital (CAH).

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Competitive Bidding Program

- You're affected by this program if you live in (or are visiting) certain ZIP codes
  - Sacramento
    - 94230

(Cont'd) Competitive Bid - Equipment & Supplies

Examples of items that fall into the Competitive Bid Categories for zip code 94230:

- Continuous Positive Airway Pressure (CPAP) Devices
- Oxygen Equipment and Supplies
- Scooters
- Wheelchairs (Manual and power)
- Enteral Nutrients, Equipment and Supplies
- Hospital Bed
- Mail-Order Diabetic Supplies

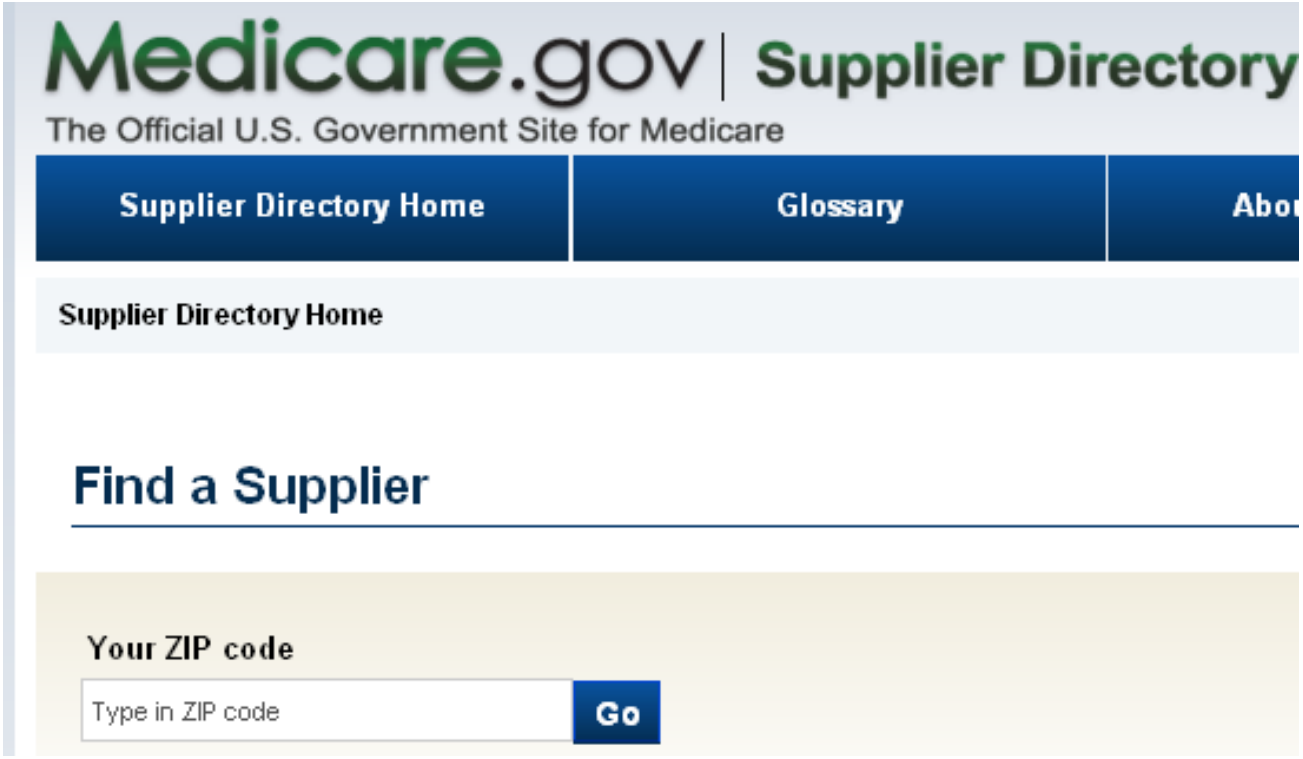
Durable Medical Equipment
- DME -

- Supplier must be Medicare-approved
- Medical necessity must be documented
- DMEPOS Competitive Bidding Program
  - Pre-approval of wheelchairs
- http://www.medicare.gov/SupplierDirectory/

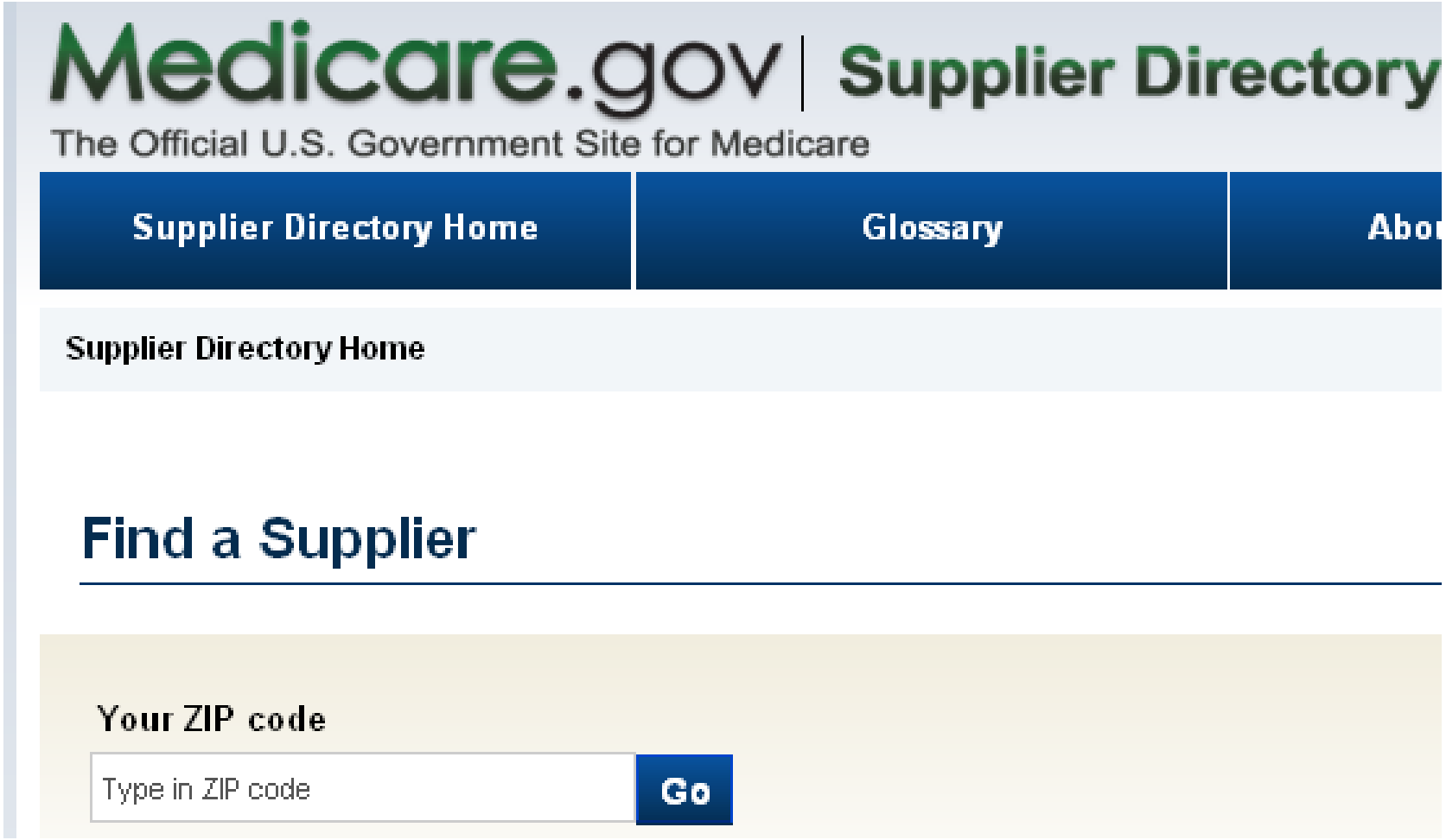
Competitive Bidding Program

- Affects:
  - Permanently reside in, or are visiting, a Competitive Bidding Area (CBA) and obtain competitively bid items
- Supplier Locator

  Toolhttps://www.medicare.gov/supplierdirectory/search.html



Zip Code


Medicare.gov | Supplier Directory
The Official U.S. Government Site for Medicare
Supplier Directory Home
Glossary
Abou
Supplier Directory Home
Find a Supplier
Your ZIP code
Type in ZIP code
Go

Zip Code 94230

Competitive Bid Categories

Mail-Order Diabetic Supplies View Examples

- [ ] Mail-Order Diabetic Supplies

Enteral Nutrients, Equipment and Supplies View Examples

- [ ] Enteral Nutrients

General Home Equipment and Related Supplies and Accessories View E

- [ ] Commodes, Urinals, Bedpans
- [ ] Hospital Bed
- [ ] Patient Lifts
- [ ] Seat Lift Mechanisms
- [ ] Support Surfaces (Group 1 & 2)

Nebulizers and Related Supplies View Examples

- [ ] Nebulizers and Related Supplies

Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies an

- [ ] NPWT Pumps and Supplies

Respiratory Equipment and Related Supplies and Accessories View Exa

- [ ] Continuous Positive Airway Pressure (CPAP) Devices
- [ ] Oxygen Equipment and Supplies
- [ ] Respiratory Assist Devices (RADs)

Standard Mobility Equipment and Related Accessories View Examples

- [ ] Power Operated Vehicles (Scooters)
- [ ] Walkers
- [ ] Wheelchair Seating/Cushions

Zip Code 94230 - Walker

Standard Mobility Equipment and Related Accessories 1

- [ ] Power Operated Vehicles (Scooters)
- [x] Walkers
- [ ] Wheelchair Seating/Cushions
- [ ] Wheelchairs (Standard Manual)
- [ ] Wheelchairs (Standard Power)

Advanced Search

Search

Zip Code 94230 – Walker Suppliers

Your search results for ZIP code 94230 are displayed below.

Important: Use the contact information below to place an order with a Medicare contract supplier (identified with a ☆). Contract suppliers are required to provide competitive bid equipment and supplies (identified with a ☆) throughout the entire competitive bidding area. Medicare's payment for the equipment includes delivery, set-up, and patient training.

If you have additional questions, please call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048.

Show All Results | Hide All Results | Print All Results

▶ All Your Product Categories (1 result)

▶ Walkers (18 results) ☆

For Zip Code 94230
18 Walker Suppliers on 5/19/17

BENNETT MEDICAL SERVICES INC 9412 BIG HORN BLVD 1 ELK GROVE, CA 95758 (916) 681-0111 No toll-free number provided	**5.95 Miles**
FLORIDA HOME MEDICAL SUPPLY, INC. 614 E ALTAMONTE DR ALTAMONTE SPRINGS, FL 32701 (407) 849-6455 1-800-294-1430	**2,982.66 Miles**

Every supplier on this list must be able to provide the service for this zip code; they might sub-contract to a more local supplier

Medicare's payment includes equipment delivery, set-up, and patient training.

Accepting assignment: always ask if a supplier will accept assignment for the item you are ordering or your patient pays more out-of-pocket

DMEPOS Costs & Travel

- If the supplier cannot or will not provide the equipment prescribed for the beneficiary, the supplier shall notify the treating practitioner or other health team member promptly within 5 calendar days.

- It is not considered traveling when beneficiaries are admitted to hospitals outside of their area, need equipment and upon discharge go back home.

- When people with Original Medicare travel to or visit a Competitive Bidding Area (CBA) and need to get equipment or supplies that are part of the Competitive Bidding Program for that CBA, they must almost always get those items from a contract supplier for that CBA.

DME Highest %

2011 Original Medicare Improper Payment Error Rate

Error Rate and Projected Improper Payment by Claim Type:

Service Type	Nov 2011
Inpatient Hospitals	7.9%
DME	61.0%
Physician/Lab/Ambulance	9.2%
Non-inpatient hospital facilities	4.4%
Overall	8.6%

- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2011-Fact-sheets-items/2011-11-156.html

2017 Issues

- Braces (arm, leg, back, and neck)
- Ambulance
- Lab Services
- Chiropractic Services
  - CMS continues to deny many chiropractic claims because they do not meet Medicare requirements. During the 2015 reporting period, the Medicare Fee-For-Service (FFS) improper payment rate for chiropractic services was 51.7%, representing approximately $300 million in improper payments and accounting for 0.7% of the overall Medicare FFS improper payment rate.
- Possible overuse of observation status

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Who commits fraud?

- Most individuals & organizations are honest
- Anyone can commit fraud
  - Health care providers and suppliers
    - Physicians, therapists, pharmacist, durable medical equipment (DME) suppliers, etc.
  - Business owners and employees
  - Billers of insurance
  - Beneficiaries with Medicare/Medicaid
- Stolen identities

DUALS – Medicare & Medicaid "Medi-Medi"

Is this Fraud or an Error?

A. Dual beneficiary sees a physician.
   – Physician collects the 20% co-payment

B. Physician has beneficiary sign a contract to allow the physician to collect co-payment instead of charging MediCal

What Do You Do?

Compromised Medicare Number

- Notify Police – get police report
- Monitor MSN (Medicare Summary Notice issued quarterly)
  - Call 1-800-MEDICARE to report errors
- Notify Bank
- Notify 3 Credit Report Agencies
  Experian, TransUnion, and Equifax

CMS response to reported concern

- Investigate
  - Gather facts through phone calls, medical records, etc.
  - Human/computer error vs. fraud
- Billing
  - Edit provider bills
  - Duplicate submission
- Educate
  - Coding errors

Types of actions for fraud

- Deny individual claims
- Prepay/postpay review as an investigative technique
- Revoke providers for improper practices
  - Temporary or permanent exclusion from Medicare
- Collaborate with law enforcement before, during and after case development
- Addresses the root cause of identified vulnerabilities

Inpatient vs. Observation Stay

Hospital status → how much you pay for services

- **Inpatient**
  - **S**tarts the day formally admitted to the hospital with a doctor's order
  - The day **before** you're discharged is your last inpatient day

- **Outpatient**

  Doctor **hasn't** written an order to admit you to the hospital as an inpatient → you're an outpatient even if you spend the night at the hospital.
    - Emergency department services
    - Outpatient surgery, lab tests, or X-rays
    - Observation services

Observation services

- Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged.

- Observation services may be given in the Emergency Department (ED) or another area of the hospital
  - Person is *not admitted* to the hospital

- Self-administered drug fees

“self-administered drugs”

Self-administered drug

- A medication that you can give to yourself, such as:
  - Pills
  - Injections such as insulin, heparin

- Prescription drug coverage (Part D) may cover the drugs under certain circumstances
  - if the situation warranted the out-of-network access
  - Part D plan is only required to reimburse the beneficiary the amount that it would have paid had the beneficiary obtained the drugs at a network pharmacy. The beneficiary remains responsible for any differential between what the hospital charged and the Part D plan reimbursement, although the entire amount paid by the beneficiary would count toward the true-out-of-pocket (TrOOP) expenses.

- You likely will need to pay out-of-pocket
  - Then submit a claim to your drug plan for a refund.
  - Pay only the amount of an in-network pharmacy

Qualifying Stay

For Skilled Nursing Facility (SNF)/Rehabilitation

Need BOTH:

- 3-day inpatient admission required

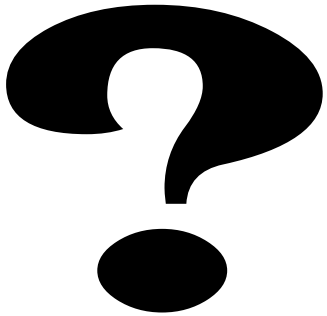
  &

- M.D. documentation
  - Need medical justification

Most common out-of-pocket costs

- **Failure to meet the 3-day stay** requirement often results in the most significant out of pocket financial responsibilities for post hospital skilled nursing care (SNF)
  - self-administered drugs
  - Deductible
  - Copayment

QUESTIONS ?



Chronic Care Management
CCM

Chronic Care Management (CCM) services by a physician or nonphysician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff, per calendar month

for patients with **multiple (two or more) chronic conditions** expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only 1 practitioner can bill CCM per service period (month).

CCM – FQHC Billing

- Chronic Care Management can be billed as a stand-alone visit or on the same claim as a billable encounter. The FQHC will report 99490. The payment for the CCM is separate from the FQHC PPS encounter.
  - So if they bill it alone, they are reimbursed the Fee Schedule amount for 99490. For **2017** – the payment rate is $43. There is no GAF or coinsurance applied to this service. When reporting this as a stand-alone visit, an FQHC payment (G-code) is not required.
- If the CCM occurs during an otherwise billable encounter, then the FQHC would receive the payment for their encounter and the CCM rate when billed with 99490 separately. CR 9234/MM9234 provides some good information and examples.

Prior Authorization

- Durable Medical Equipment Medicare Administrative Contractors (DME MAC) reviews prior authorization requests for scooters and power wheelchairs
  - Collectively referred to as PMDs

Prior Authorization of PMDs

The PMD Demonstration covers:

- Scooters- costing $1500 or more
- Power wheelchairs- costing upwards of $3,600 over the course of the rental

- The PMD Demonstration started in September of 2012 in the 7 highest fraud states: CA, IL, MI, NY, NC, FL and TX
  - These 7 states accounted for 43% of the roughly $606 Million spent annually on PMDs
  - Demonstration was extended for an additional three years and will end August 31, 2018.

- **What prompted this demonstration?**
  - HHS OIG recently reported that **80 %** of claims for power wheelchairs did not meet Medicare coverage requirements.

Prior Authorization of PMDs

was delayed so that CMS could adopt changes in Response to Industry Feedback
The following are 4 concerns raised by suppliers that resulted in changes to this program::

Concern	REVISED Demonstration Process
Supplier may be financially impacted by the 100 %prepayment review phase of the demonstration.	The Demonstration has **eliminated** prepayment review (formerly called Phase 1) and will go straight to Prior Authorization.
The ordering physician may not be in the best position to submit the prior authorization request.	The physician/ treating practitioner **or** supplier on behalf of the physician/ treating practitioner may perform the administrative function of submitting the Prior Authorization request.
Some states will be under 100 % prepayment review while other states are using prior authorization.	All demonstration states will start prior authorization at approximately the same time.
There was limited notice given prior to the proposed start date.	•CMS has delayed the implementation until Summer 2012. •CMS has submitted a separate PRA package. This allowed providers and supplier at least 60 days to comment on the collection of information burden of the demonstration. •CMS plans a Federal Register Notice announcing the start date. •CMS will send certified letters to suppliers and practitioners in the demonstration states.

Prior Authorization of PMDs

- Ordering **practitioner or supplier** submits a prior authorization request to the DME MAC
- DME MAC reviews the request; postmark notification of a written decision within **10 days** to the practitioner, Beneficiary and Supplier.
- The DME MAC will:
  - Affirm (approve) the request **or**,
  - Non-affirm (deny) the request. If non-affirm, DME MAC will provide detailed written explanation outlining which specific policy requirement(s) was/were not met.
    - **Unlimited requests** may be submitted.
    - DME MAC will review SUBSEQUENT requests within **20 days**.

Prior Authorization of PMDs

4 Scenarios

A prior authorization request is	The DME MAC decision is to	The supplier chooses to	The DME MAC will
Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met)
Submitted	Non-affirmative	Submit a claim	Deny the claim.
If the supplier is in a Competitive Biding Area			
Not submitted for DME MAC Review	N/A	Submit a claim **(by a Competitive Bid Supplier)**	Sends ADR (additional Documentation Request) to supplier. Review the claim. If payable, pay at normal rate.
Not submittedfor DME MAC Review	N/A	Submits a claim **(by a Non- Competitive Bid Supplier)**	Sends ADR to supplier. Review the claim. If payable, pay at 75% of Medicare payment.*

Common reasons for DME denial

- Common reasons for DME payment denials
  - https://med.noridianmedicare.com/web/jddme/cert-review/mr/complex-notifications-results

Review Criteria	Current Error Rate	Service Specific Review Notification	Current Review Results
K0001: STANDARD WHEELCHAIR	54%	•View Probe Notification •View Targeted Notification	View Results Info pulled on 10/24/16

Common reasons for DME denial

- Common reasons for DME payment denials
  - https://med.noridianmedicare.com/web/jddme/cert-review/mr/complex-notifications-results

Review Criteria	Current Error Rate	Current Review Results
K0001: STANDARD WHEELCHAIR	54%	View Results

- The quarterly edit effectiveness results from April 2016 - July 2016
  - The K0001 review involved 868 claims, of which 519 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **54%**.
  - WHY? What were the **Top Denial Reasons**

Common reasons (cont'd)

- The quarterly edit effectiveness results from April 2016 - July 2016
  K0001 review of 868 claims: **Top Denial Reasons**
  - Documentation was not received in response to the Additional Documentation Request (ADR) letter
  - Documentation does not support the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
  - Documentation does not support the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day
  - Documentation does not support the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair
- See sample template

(cont'd) Common reasons

- Common reasons for DME payment denials
  - https://med.noridianmedicare.com/web/jddme/cert-review/mr/complex-notifications-results

Review Criteria	Current Error Rate	Current Review Results
E0439: STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING	55%	View Results Info pulled on 10/24/16

Reasons for denial of HCPC E0439

- **Top Denial Reasons** for Oxygen HCPC E0439
  - Documentation was not received in response to the Additional Documentation Request (ADR) letter
  - The medical record documentation does not support that alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy
  - The medical record documentation does not support the treating physician has determined that the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy
  - Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements

Elements to a standard Medicare Detailed Written Order - WOPD

- Beneficiary's name
- Physician's Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI),
- The signature of the ordering practitioner
- Signature date

Elements to a standard Drug Order

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

Date and Timing Requirements

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.

- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.

- The date of the written order must be on or before the date of delivery.

- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

- A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date.

Detailed Written Order (DWO)

- For items provided based on a 5EO, supplier must obtain a detailed written order before submitting a claim
- May be completed by someone other than physician
  - Treating physician must review, sign and date
- Acceptable orders
  - Fax
  - Photocopy
  - Electronic
  - Original pen and ink

Date and Timing Requirements ACA Items

- F2F Evaluation
  - On or before date on the WOPD/5EO
  - No older than 6 months prior to WOPD/5EO
  - Must be on or before delivery of DME
    - Date stamp (or equivalent)
- WOPD/5EO
  - Date of WOPD/5EO must be on or before date of delivery or Date of Service
  - Must have completed WOPD/5EO BEFORE delivery
    - Date stamp (or equivalent)

Face-to-Face and 5EO Date Stamp Requirements

- Must clearly indicate supplier's date of receipt of both the face-to-face record and the completed 5EO, including year
- Medical records must be final version
- Must be evident the supplier received these documents PRIOR to dispensing the item

FAQ

Q: Does the ordering physician have to be the same physician that conducts the face-to-face evaluation?

A: No. The physician that signs the WOPD does not have to be the same physician that conducts the face-to-face evaluation.

- Prescriber must have knowledge and documentation that the F2F evaluation was conducted.

Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment - CGM

- On January 12, 2017, CMS issued a ruling (CMS-1682-R) classifying certain continuous glucose monitors as Durable Medical Equipment if the equipment:
- Is approved by the Food and Drug Administration (FDA) for use in place of a blood glucose monitor for making diabetes treatment decisions (including the Dexcom G5 Mobile CGM monitor/supplies)
- Is generally not useful to the individual in the absence of an illness or injury
- Is appropriate for use in the home
- Includes a durable component that is capable of displaying the trending of the continuous glucose measurement
- Billing and coverage instructions addressing the ruling will be issued by your Medicare Administrative Contractor (MAC).

https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf

MEDICARE PREVENTIVE SERVICES

ss	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use
t	Glaucoma Screening	Hepatitis B Virus (HBV) Vaccine and Administration	Hepatitis C Virus (HCV) Screening	Human Immunodeficiency Virus (HIV) Screening
ioral for ar	Intensive Behavioral Therapy (IBT) for Obesity	Lung Cancer Screening	Medical Nutrition Therapy (MNT)	Pneumococcal Vaccine and Administration

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

MLN – Medical Nutrition Therapy (MNT)

HCPCS/CPT Codes

97802 - MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 - MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes

97804 - MNT; group (2 or more individual(s)), each 30 minutes

G0270 - MNT reassessment and subsequent intervention(s) for change in diagnosis, medical condition or treatment regimen, individual each 15 minutes

G0271 - MNT reassessment and subsequent interv in diagnosis, medical condition or treatmer more), each 30 minutes

Who Is Covered

Certain Medicare beneficiaries when all of the following are true:

- Receive a referral from their treating physician
- Diagnosed with diabetes or renal disease, or who have received a kidney transplant within the last 3 years
- Service provided by a registered dietitian or nutrition professional

Frequency

- First year: 3 hours of one-on-one counseling
- Subsequent years: 2 hours

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

RESOURCES

- Medicare.gov
  - Supplier Locator Tool Medicare.gov/supplier
  - Special Open Door Forums

    https://www.cms.gov/outreach-and-education/outreach/opendoorforums/ODFspecialODF.html
- Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048
- Contractors
  - Noridian: https://med.noridianmedicare.com/
  - NGS: NGSMedicare.com
- Medicare fraud tip line 1-800-HHS-TIPS (1-800-447-8477)

Senior Medicare Patrol (SMP)
Health Insurance Counseling & Advocacy Program (HICAP)
State Health Insurance Assistance Program (SHIP)

- Provide *FREE* help to beneficiaries explaining Medicare rights and benefits including:
  - How to appeal denials of coverage
  - Medicare supplemental insurance (Medigap policies)
  - Medicare Advantage plans
  - Prescription Drug Plan coverage
- Provide free educational presentations on Medicare in the community
- California HICAP 1 - **800 - 434 – 0222**

  http://cahealthadvocates.org/

Additional RESOURCES

MEDICARE 1-800-MEDICARE (1-800-633-4227)

SFRO Medicare Divisions	Division Mailbox	Phone number
Managed Care (Health Plans)	rosfodhpp@cms.hhs.gov	(415) 744 - 3602
Fee-For-Service (Traditional Medicare)	rosfofm@cms.hhs.gov	(415) 744 - 3658
Medicaid	ROSFOMCD@cms.hhs.gov	(415) 744 – 3568
Survey & Certification	ROSFOSO@cms.hhs.gov	(415) 744 – 3696

Resources - Noridian

- LCD/Policy Article
  - https://med.noridianmedicare.com/web/jddme/policies
- Supplier Manual
  - https://med.noridianmedicare.com/web/jddme/education/supplier-manual
- “Dear Physician” letters
  - https://med.noridianmedicare.com/web/jddme/policies/physician-resources
- Documentation Checklist
  - https://med.noridianmedicare.com/web/jddme/policies/documentation-checklists

CBIC Liaison (CBL)

Phabian E. Barrett

(803) 763 - 5771

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