A CMS Medicare Administrative Contractor
http://www.NGSMedicare.com

Jurisdiction B Council Questions

Sorted by A-Team
October 24, 2013

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.gov.

Enteral/Parentral/IV Therapy

1. **Question on test of permanence for total parenteral nutrition (TPN)/enteral nutrition (EN) in combination: If patient is on enteral tube feeds with a qualifying functional impairment (dysphagia and aspiration) and permanent condition for enteral, however suddenly does not tolerate tube feedings and requires TPN for short term (a few weeks or so) to further evaluate, in addition physician plans to restart transitional tube feeds along with TPN to see if patient can tolerate tube feedings again. Is the TPN considered as meeting the test of permanence since in conjunction with the long term enteral therapy? In other words, when TPN and enteral nutrition are administered interchangeably, and combined duration is 90 days or greater, therefore the test of permanence is met for nutritional support, will both the TPN and EN qualify or do they independently have to stand on their own in order to be considered for coverage?**

   Answer: In order to qualify for TPN coverage by Medicare, the criteria set forth in the policy article must be met. Permanent impairment is a requirement for both enteral and parenteral policies, but the additional required criteria must be met and stand on their own for consideration for parenteral. (Same question as submitted to Jurisdiction D Durable Medical Equipment Medicare Administrative Contractor [DME MAC] Advisory Committee.)

Home Medical Equipment

No questions submitted.

Oxygen

2. **Please clarify the following requirement: "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." Does this mean that we can or cannot use Hypoxia/Hypoxemia/Dyspnea, etc. as a primary diagnosis for billing?**

   Answer: This policy is not diagnosis driven. We do not accept the diagnosis alone as proof that the medical necessity criteria are met. Therefore, we would expect that the medical record would contain the clinical information to show that the criteria in the policy are met. From the oxygen and oxygen equipment local coverage determination (LCD):

   "*Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:*

   1. *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, and*
   2. *The beneficiary's blood gas study meets the criteria stated below, and*
   3. *The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and*
   4. *The qualifying blood gas study was obtained under the following conditions:*
      - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
      - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
   5. *Alternative treatment measures have been tried or considered and deemed clinically ineffective.*"

3. **Regarding oxygen testing: Medicare states that testing on exertion needs to be done in the same testing session. Please clarify if the following would qualify as the "same session"? Patient was tested at 8:00 a.m. on room air, second test on room air on exertion at 11:25 a.m. (four hours later), final test on exertion on two liters (L) of oxygen five minutes later at 11:30 a.m.**

   Answer: No.

4. Does a new signed and dated detailed written order for oxygen, not a 484 Certificate of Medical Necessity (CMN), if done annually (preceding 12 months), meet the requirements for continued medical need?

   Answer: Yes. The LCD for oxygen states:

   "*CONTINUED MEDICAL NEED*

   For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's

medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. *A recent order by the treating physician for refills*
2. *A recent change in prescription*
3. *A properly completed CMN or DIF with an appropriate length of need specified*
4. *Timely documentation in the beneficiary's medical record showing usage of the item.*

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy."

5. **Due to the oxygen audits there are times the initial CMN is tied up with an audit and does not show on file. (The portable CMN is on file.) If a patient transitions to a new company a few months after they were setup, what type of CMN should the provider obtain? My initial thought is a revised CMN but what happens if the originating provider's claims are denied for technical reasons? Does that initial CMN ever enter Common Working File (CWF)?**

   Answer: A claim that has been denied during an audit due to a technical reason will process through the CWF. However, if the CMN for the stationary equipment is not on file, the supplier should submit the claim after the original supplier's claim has been adjudicated and the CMN is on file. The supplier should obtain a revised CMN.

6. **The CMS has announced that, effective immediately, it will allow the replacement of oxygen equipment when suppliers exit the business. In a bulletin, CMS stated that, under such circumstances, it will now consider the equipment lost and start a new 36-month rental period for the new supplier on the date the equipment is furnished. CMS noted that suppliers exiting the business without transferring patients to new suppliers are in violation of statutory and regulatory requirements.**

   - **Does this apply everywhere? Both in and out of Bid Areas?**
   - **What "proof" of "loss" will CMS require and must this accompany the first claim?**
   - **Will new qualifying information need to be obtained or will old qualifying information suffice if available?**
   - **What legal actions does CMS intend to deploy against companies that go out of business and are in violation of statutory and regulatory requirements?**
   - **What statutory and regulatory requirements do businesses going out of business have in relation to home oxygen patients (or for any other durable medical equipment (DME) items)?**
   - **Does this new rule apply only to oxygen or does it apply to all other DME that might have been abandoned by a business going under.**

Answer: At this time, National Government Services does not have any additional information. We are awaiting additional information from CMS. Once received, the information will be shared with the supplier community via e-mail update.

7. **The Medicare policy states, for beneficiaries initially meeting group I or II criteria the beneficiary must be seen and reevaluated by the treating physician within 90 days prior to the date of any Recertification. If the physician visit is not obtained within the 90-day window but the beneficiary continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.**

   Example:

   Initial Date: 03/01/12
   Physician visit: 05/13/13
   Recert Date: 05/13/13

   Can the provider bill for 03/01/13, 04/01/13, and 05/01/13 and be paid?

   Answer: Our assumption is this would be for a Group 1 patient. For group I, recertification is due 12 months after initial certification (i.e., with the thirteenth month's claim). Once the initial certification expires, there is no billing that is payable until the recertification requirements are met. In the scenario above, the supplier would submit claims for 03/01/12 through 02/01/13 assuming the beneficiary continues to need and use the equipment. Since recertification did not take place until 5/13/13, the supplier cannot bill for 03/01/13, 04/01/13, or 05/01/13. The supplier could not submit another claim until the recertification had been completed on 05/13/13. Therefore, the next claim could be dated 05/13/13, which would change the anniversary date, or it could be dated on the anniversary date of 06/01/13 if the supplier chose to wait and submit the claim, or the supplier could choose any date in-between 05/13 and 06/01/13 if preferred (again, which would change the anniversary date).

Positive Airway Pressure (PAP)/Other Respiratory Care Equipment

8. **If a patient has obstructive sleep apnea (OSA) as diagnosis, but cannot tolerate a PAP device and physician orders oxygen due to pulse ox of 85 percent for greater than five minutes during nocturnal pulse oximetry, can a patient qualify for oxygen only?**

   Answer: OSA is not a condition that qualifies a beneficiary for oxygen. Oxygen is covered by Medicare for persons with hypoxemia. Oxygen is not a first line treatment for untreated OSA. Other therapies must be used. The oxygen LCD requires that a beneficiary be in the "chronic stable state" before being administered oxygen and this includes having any existing OSA optimally treated. The only way to meet the requirement for coverage of oxygen with OSA is to have evidence that the OSA is optimally treated, and then there would be another condition that is the reason oxygen is necessary. An overnight titration study is required to show this. Please refer to the policies on oxygen and on PAP for specifics.

9. **A patient has been on a PAP device for a number of months and the physician wants a nocturnal pulse oximetry done to determine if the patient needs supplemental oxygen bled into**

the PAP device. At this point can the physician order a nocturnal pulse ox on the PAP device by an independent diagnostic testing facility (IDTF) in the home or does the patient have to have a titration in a lab?

Answer: A titration study is required as per the PAP LCD. Please refer to the policies on oxygen and on PAP for specifics.

10. **The oxygen and PAP rules were updated 01/01/13 with the statement that only a titration study can determine the need for oxygen if the patient has OSA. If a patient (on both oxygen and PAP device) transitions to Medicare from another insurance the provider needs to make sure the patient meets both the PAP policy and the oxygen policy. Typically the provider would request a nocturnal oxygen test where an IDTF would go to the home and perform the nocturnal pulse oximetry while on a PAP device to determine if the patient has an oximetry value of 88 percent or below for at least five minutes.**

    With the oxygen policy change, is the patient now required to go to a sleep lab and go through a titration study in order to qualify for the oxygen? (New sleep study not required for PAP device/supplies as long as it meets Medicare criteria and patient has seen the physician and discussed PAP needs and benefits after enrolling in Medicare).

    Answer: Definitions for qualifying testing types were added to the oxygen LCD in January 2013 in order to minimize confusion with other respiratory testing performed. Patients who are transitioning into Medicare from other payers are considered new initial patients for Medicare purposes. For each item being submitted to Medicare, the patient must qualify and meet those specific LCD requirements.

11. **The respiratory assist device (RAD) LCD used to indicate "continuous" when discussing oxygen saturations. The policy stated "oxygen saturation less than or equal to 88% for at least five continuous minutes...." As of 02/01/10 the policy now states "less or equal 88% of nocturnal recording time (minimum recording time of 2 hours)." The policy revisions do not detail this change. Does the 88% desaturation need to be continuous"?**

    Answer: No. The "continuous" requirement was removed in 2010.

12. **The RAD policy states: Coverage of a PAP device for the treatment of OSA is limited to claims where the diagnosis of OSA is based upon a sleep test (Type I, II, III, IV, Other) that meets the Medicare coverage criteria in effect for the date of service of the claim for the PAP device. The sleep test must be either a polysomnogram (PSG) performed in a facility-based laboratory (Type I study) or a home sleep test (HST) (Types II, III, IV, Other). The test must be ordered by the beneficiary's treating physician and conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements. A list serve message sent out on 07/30/2013 states: A single level PAP device (E0601) is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram.**

    Since policy does allow the use of PSGs and home studies, would you consider revising this list serve message to state something that indicates PSG or home study, for example:

A single level PAP device (E0601) is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) documented by a sleep test that meets Medicare coverage criteria.

Answer: The listserv message sent out on July 30, 2013, "Diagnosis Requirements for Positive Airway Pressure (PAP) Devices" will be revised and reissued.

Prosthetics/Orthotics

13. Can you please confirm that a new detailed written order is required for component replacement (e.g., knee, foot, pylon, socket) of an orthotic/prosthetic device?

Answer: As stated in both the knee orthoses policy and the ankle-foot-knee orthoses policy, when replacing an item, a new order is required to reaffirm the medical necessity of the item. Per the Lower Limb Prostheses Policy, a new order is required for replacement of a major part or component of a lower limb prosthesis.

14. Is there any update on the issue of coverage of prosthetic covers and flexible outer protective covering systems on the same prosthesis. The policy clarification published in July 2013 indicated that both of these would only be eligible for coverage in limited circumstances involving especially harsh conditions. Is there any additional information available regarding this issue?

Answer: This article remains in effect. After a review of the historical development of these codes, it is clear that the payment for the cover when it was originally bundled into the prosthetic component was for a completely finished cover. The unbundling of the cover from the underlying component did not further unbundle the elements necessary for a complete and furnished cover.

L5962 (addition, endoskeletal system, below knee, flexible protective outer surface covering system), L5964 (addition, endoskeletal system, above knee, flexible protective outer surface covering system), and L5966 (addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system) are separate protective covering systems that were developed long before the creation of L5704-L5707 which are the prosthetic covers. An analysis of the products included in these covering system codes clearly indicates their usage is not for routine finishing but is to be a covering for harsh or extreme conditions.

15. The certifying statement for therapeutic shoes has a line for HICN (Health Insurance Claim Number). The LCD states that "the form used must contain all of the elements contained on the recommended form attached to this LCD." This field is often not completed by the certifying physician. May the supplier enter this information after signature by the certifying physician as it is not related to medical necessity?

Answer: No.

Rehab Equipment

16. **Providers in Jurisdiction B have been receiving high volumes of recoupment/overpayment requests for paid claims for E1028 hardware. The Medicare Recovery Auditors appear to be identifying overpayments on any claim that included code E0950 tray. We know that we can't bill for the E1028 that is used with a tray when we bill for the E0950. But it appears that Region B Recovery Auditor is assuming that any E1028 code that was billed on the same claim that also has an E0950 is paid in error and they are recouping all of them. Most if not all of the E1028s were for hardware used with other components where policy allows separate payment for adjustable hardware. It appears that the narratives submitted with the E1028 claims are not being read. This started in July, and overpayments have been identified on claims dating back to 2011.The recoupments are being appealed but there are way too many claims that we need to appeal and this is clearly an error. What can we do to (1) stop these invalid recoupments, and (2) allow for a mass adjustment rather than individual appeals on E1028s that have incorrectly been recouped? Examples can be provided.**

    Answer: National Government Services brought this issue to the attention of the recovery auditor on October 28th. The recovery auditor agreed to remove the edit. A mass adjustment will not be conducted. If a supplier receives an overpayment request from the Medicare recovery auditor and disagrees with the determination, the supplier may pursue the issue via the appeals process or contact the Medicare recovery auditor. Multiples claim may be grouped together during the appeal process (claim limit of 299), but the determinations will be to be handled individually (the suppliers will receive individual responses).

17. **We are having difficulty submitting power mobility device (PMD) prior authorization requests (PAR) using electronic submission of medical documentation (esMD). Is there a contact person who can help with esMD issues?**

    Answer: Suppliers should contact their Health Information Handler (HIH) if they are having difficulty submitting requests via esMD. The supplier's HIH will provide details on how to properly submit an esMD transmission. A couple of items to remember when using esMD:

    - Indicate the type of documentation you are sending. Suppliers using esMD must send the correct "Content Type Code" in their esMD transmissions. The appropriate "Content Type Codes" are:
        - 1 - When Responding to an Additional Documentation Request (ADR)
        - 8 - PMD Prior Authorization Request (PAR) submissions

    Submitting an incorrect "Content Type Code" during an esMD submission will cause your documentation to be routed incorrectly once received by the DME MAC and the documentation you submit will not be available to the appropriate department. This may cause unnecessary denials. If unsure how to indicate whether the documentation submitted is related to an additional documentation request or PMD PAR, contact your HIH.

    - Details on the types of files and file sizes should also be coordinated with your HIH.
    - Correctly communicate the contractor and line of business with your HIH, so the esMD documentation goes to the appropriate Medicare contractor.

Ostomy/Urological/Medical Supplies

No questions submitted.

Diabetic Monitoring and Supplies

18. In regards to diabetic testing logs, for patients testing above the frequency prescribed, is the only additional documentation the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) supplier needs to provide the DME MAC upon request the medical record from the physician documenting the necessity for the patient's utilization above the set criteria?

Answer: No. There must be compliance with ALL of the relevant policy criteria. For example the supplier will need to provide appropriate prescriptions, refill documentation, continued use and continued need justification, and proof of delivery information (not an exhaustive list) as discussed in the policy. Please remember that suppliers may not directly collect beneficiary testing information (logs) and submit them to the DME MAC to demonstrate medical necessity for overutilization. However, DMEPOS suppliers may collect the logs from the beneficiary voluntarily to demonstrate continued use.

Documentation/Regulatory/Miscellaneous/Other

19. If documentation (signed chart notes, CMNs, physician orders etc....) is scanned in an electronic format that is easily retrievable, is there any reason to keep hard copies on file?

Answer: Please note that there is no specific legal direction for suppliers in regard to electronic record format other than medical records, but there is direction on retention of records. Per CMS Internet-Only Manual (IOM) 100-08, *Medicare Program Integrity Manual*, Chapter 5, Section 5.8, documentation must be maintained in the supplier's files for seven years. Per CMS Special Edition article SE1022, the Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly. Providers may want to obtain legal advice concerning both retention of records after seven years and medical documentation format.

20. Regarding the CMS announcement that it will delay enforcement of Section 6407 of the Affordable Care Act (ACA) that requires face-to-face until sometime in 2014. The announcement refers to delaying the enforcement of the face-to-face requirements, but is silent regarding enforcing the written order requirements. Will any CMS contractors be auditing files for the presence of the written order before delivery that is required under the statute, or is the enforcement of both the face-to-face and the written order being delayed?

Answer: The effective date was 07/01/2013. Enforcement is delayed. No other instructions have been issued by CMS at this time.

21. For the face-to-face encounter rule, is it correct that whenever a new detailed written order is needed that a new face-to-face encounter is also required? Are there any exceptions?

Answer: Yes, a new face-to-face encounter (F2F) is required. Based upon the information released by CMS at this time in Medicare Learning Network (MLN) Matters article 8304, there are no exceptions.

22. When an Asset sale occurs between two suppliers, which causes a Tax Identification Number (TIN) and Provider Transaction Access Number (PTAN) change/change in supplier, if the new supplier has the patient's medical records and previous suppliers detailed written orders in their files, is a new detailed written order required for continued billing or for future supply refills? Is this published anywhere?

Answer: Per CMS IOM Publication 100-08, *Medicare Program Integrity Manual (PIM)*, Chapter 5, Section 5.2.4, a new order is required when there is a change in supplier.

23. What could a supplier do when the permanent address on file for the beneficiary is in a competitive bidding area (CBA), but he resides in a noncompetitive bidding area? The patient's daughter receives all of his mail and she lives in a competitive bid area and outside of the beneficiary's service area for oxygen. What is the supplier's recourse and also the patient's recourse?

Answer: If a beneficiary has a Power of Attorney (POA) or representative payee on file whose address is within a CBA, but the beneficiary does not reside in a CBA, claims for the beneficiary for items obtained in a non-CBA should be submitted with modifier KT appended to the Healthcare Common Procedure Coding System (HCPCS) code(s). Use of modifier KT will allow the beneficiary's claim to process as if the beneficiary had obtained the item while traveling in a non-CBA and would therefore not be subject to competitive bidding requirements. A beneficiary who does not reside within a CBA, and who obtains a DMEPOS item outside of a CBA, may obtain the item from any Medicare enrolled supplier.

24. What is the process if the DME MAC dismisses a redetermination or reopening request? A document control number (DCN) is assigned but then it's dismissed so do we go to the next appeal level or does this indicate further action is required in order for the denial to go through redetermination or reopening?

Answer: If an appeal request is dismissed the supplier may not go to the next appeal level. The supplier may submit a request for the contractor to vacate the dismissal.

A request for appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant;
2. A request is made by the appellant to withdraw the appeal;
3. A determination that an appellant is not a proper party;
4. The amount in controversy requirements have not been met; and
5. The appellant has died and no one else is prejudiced by the claims determination.
6. Untimely filing of appeal request.

The most common reason for dismissal is untimely filing of the appeal request. If a supplier has just cause for filing a late appeal, the supplier may submit a request that the contractor vacate the dismissal. If a request is submitted to vacate the dismissal, and the request contains sufficient evidence

or other documentation that supports a finding of good cause for late filing, the contractor will make a favorable good cause determination. Once it makes a favorable good cause determination, it considers the appeal to be timely filed, vacates its prior dismissal action, and performs a redetermination.

If the contractor does not find good cause to vacate the dismissal, the dismissal remains in effect. The contractor issues a letter (not a dismissal letter) explaining that good cause has not been established and the dismissal cannot be vacated. Although the appellant may not appeal a contractor's finding that good cause was not established when the appellant requested that the contractor vacate its dismissal, the appellant maintains their right to request a Qualified Independent Contractor (QIC) review of the contractor's dismissal action. However, requests for QIC review of a contractor's dismissal action must be received by the QIC within 60 days of the date of receipt of the dismissal notice.

For additional information regarding dismissals, refer to the CMS IOM 100-04, *Medicare Claims Processing Manual*, Chapter 29.

25. Please discuss how the provision under the Health Insurance Portability and Accountability Act (HIPAA) Health Information Technology for Economic and Clinical Health (HITECH) Act will impact the requirement that providers file claims for all coverable products and services. National Government Services has held in the past that a Medicare patient does not have the right to purchase a Medicare covered item out of pocket. National Government Services has made it clear that if the item is a Medicare covered item, the provider must bill Medicare. The new HIPAA Privacy Standards conflict with what their verbal policy has been.

Here is a synopsis of the requirement: Right to Request a Restriction

The Final Rule modifies 164.522 as per HITECH Act Section 13405(a) indicating that individuals have a new right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the healthcare item or service.

Covered entities (i.e. that are healthcare providers) will need to employ some method to flag, or make a notation in the medical record, with respect to Protected Health Information that has been restricted so that the information is not sent to a health plan.

Disclosures that are otherwise required by law are still permitted.

In the case of an individual who wants to restrict disclosures to a health plan concerning a prescribed medication, the prescribing provider could provide the patient with a paper prescription to allow the individual an opportunity to request a restriction and pay for the prescription with the pharmacy BEFORE the pharmacy has submitted a bill to the health plan.

The individual, and not the Covered Entity, is required to notify a downstream Health Information Exchange(s) of the restriction. Comment: it remains unclear how an individual may actually accomplish this task, however what is clear is that the healthcare provider is NOT required to do so.

A family member could make the payment on behalf of an individual and the restriction would still be triggered.

The restriction does not apply for the purpose of the covered entity collecting payment (i.e. presumably from the individual, or a family member or a collection agency) and no authorization is required. This restriction ONLY applies to covered entities that are healthcare providers.

Answer: National Government Services has not received instructions from the CMS about how the new HITECH act will be applied to beneficiaries at this time.

26. Proof of Delivery: If a Medicare beneficiary comes into the supplier's storefront, according to the National Government Services manual:

For Method 1 and Method 2, when a beneficiary receives the DMEPOS item via a storefront, the delivery address would be the store address, not the beneficiary's home address.

This is not common practice; most software systems print the customer's home address on delivery tickets/receipts, whether the item is physically delivered to the home or the customer comes to the provider's office to accept the item. There may be other indicators of the place of delivery, but it is quite unlikely to be listed in the address field. A supplier's computer system is incapable of listing their storefront address on the delivery slip when a beneficiary picks up the DMEPOS items in their store, what are the suppliers' options to document this on their delivery slip? In addition, we believe that only National Government Services has made this statement, which is not supported by the PIM or by other jurisdiction manuals.

National Government Services manual excerpt:

The delivery address on the proof of delivery (POD) record is not the correct address.

***For Method 1 and Method 2, when a beneficiary receives the DMEPOS item via a storefront, the delivery address would be the store address, not the beneficiary's home address*. If the DMEPOS item is delivered to a facility, the delivery address would be the facility address. This does not impact the place of service (POS) code that is reported on the claim. If the item is delivered for the beneficiary to use in their home, the supplier would still report POS code 12 (home) on the claim.**

Note: If suppliers are delivering DMEPOS items to a facility, the POS code on the claim would reflect the facility. At listing of valid POS codes is available in the *Jurisdiction B DME MAC Supplier Manual*, Chapter 12.

Supplier Documentation, Chapter 3
***DME MAC Jurisdiction C Supplier Manual*, Page 18**

There are three methods of delivery:

1. **Delivery directly to the beneficiary or authorized representative**
2. **Delivery via shipping or delivery service**
3. **Delivery of items to a nursing facility on behalf of the beneficiary**

Method 1—Direct Delivery to the Beneficiary

You may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

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

PIM Chapter 5, 5.8 – Supplier Documentation
(Rev. 242: Issued: 02-22-08; Effective/Implementation Dates: 03-01-08)
The three methods of delivery are:

- **Supplier delivering directly to the beneficiary or authorized representative;**
- **Supplier utilizing a delivery/shipping service to deliver items; and**
- **Delivery of items to a nursing facility on behalf of the beneficiary.**

Answer: The delivery address is the address of the place where the beneficiary receives the item. If the beneficiary picks the item up in the storefront location, then the delivery address is the address of that specific storefront and the store location's address should be on the proof of delivery. The address may be located in the header or footer, i.e., in the company's letterhead, or some other location. Both the beneficiary's address and the storefront's address may be present on the POD. For additional information, refer to the article posted to the National Government Services Web site titled, *Medicare Eligibility and Documentation Requirements for DMEPOS Items Obtained Prior to Medicare Eligibility*.

27. **Some noncontracted providers are receiving invalid denials on grandfathered claims, especially if they are just now submitting the initial month (delivered prior to July 1 but claims delayed due to obtaining medical necessity documentation) along with subsequent rental months that cross the July 1 bid program start date. Do you have any advice for providers on how to submit these claims so they do not get inappropriate denials? If denied, can these be reopened rather than appealed?**

    Answer: Examples were requested on 09/23/13 but not received.

28. **Some providers have noticed a recent trend on initial claims with CMNs attached; the claim and CMN appear to be split; the CMN is not loaded until a week or more after National Government Services receives the claim, but the claim goes through processing and denies for no CMN. Is National Government Services aware of this processing problem? Is there a solution? Examples can be provided.**

    Answer: Examples were requested on 09/23/13 but not received.