CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1183	**Date: February 8, 2013**
	Change Request 8172

SUBJECT: Revision to CWF and VMS: Reject or Informational Unsolicited Response (IUR) Edit for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provided During an Inpatient Stay

I. SUMMARY OF CHANGES: This Change Request (CR) provides guidance for a beneficiary in a Part A inpatient stay, an institutional provider (e.g., hospital) is not defined as a beneficiary's home for DMEPOS: Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay. The overpayment is DMEPOS items provided during a Medicare Part A covered Inpatient-stay.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: The CMS Recovery Audit Contractor (RAC) program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service payment process. The contractor claim data identified Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims for beneficiaries who received DMEPOS items while in an inpatient stay in a hospital. The payments associated with these claims are considered overpayments because Medicare does not allow separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. These claims were related to DME date of service greater than 2 days prior to Part A discharge date or Part A discharge status was not to home. This Change Request (CR) will prompt the Common Working File (CWF) to create a line item rejection for these claims if DMEPOS Claim Status is unpaid or a line item IUR if DMEPOS Claim Status is paid.

B. Policy: 1) Medicare Claims Processing Manual Chapter 20 Section 210

According to CMS Pub 100-04, Claims Processing Manual, Chapter 20, the DMEPOS benefit is meant only for items a beneficiary is using in his or her home. For a beneficiary in a Part A inpatient stay, an institutional provider (e.g., hospital) is not defined as a beneficiary's home for DMEPOS, and so Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

2) Medicare Claims Processing Manual Chapter 20 Section 110.3.1

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. The 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.

3)Medicare Claims Processing Manual Chapter 20 Section 110.3.2

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.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility						
		A/B MAC	D M E	F I	C A R	R H H	Shared-System Maintainers	Other

		Part A	Part B	MAC		RIER	I	FISS	MCS	VMS	CWF	
8172.1	The Common Working File (CWF) shall create a line item rejection for a DME claim received on or after implementation datewhen the following conditions exist: • There is a current DME claim; • AND – There is a covered Medicare Part A inpatient claim with a TOB of 111 • AND – The DME and the I**np**atient claims are for the same beneficiary HIC ID; • AND – The DME claim has a line item within the HCPCS category 03 for Orthotics **AND/OR** Prosthesis; • AND - The DME item's From Date of Service (DOS) is within the Part A Admit and Discharge Dates; • And the From DOS of the DME line items is greater than two (2) days prior to the beneficiary's Part A inpatient discharge date; • CWF shall reject the DME claim line items based upon the criteria listed above.										X	
8172.2	The Common Working File (CWF) shall create a line item rejection for a DME claim received on or after implementation date when the following conditions exist: • There is a current DME claim; • AND – There is a covered Medicare Part A inpatient claim with a TOB of 11x; • AND – The DME and the Inpatient claims are for the same beneficiary HIC ID; • AND – The DME claim has a line item within the HCPCS category 03 for Orthotics **AND/OR** Prosthesis; • AND - The DME item's From Date of Service (DOS) is within the beneficiary's Part A admit and discharge dates; • AND – The beneficiaries Part A Claim Discharge Status is not 01; • CWF shall reject the DME claim line items.										X	
8172.3	The Common Working File (CWF) shall pay the appropriate DME line items for a DME claim on or after implementation date when the following conditions exist: • There is a current DME claim for a Medicare beneficiary HICN;										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	• AND – There is a covered Medicare Part A inpatient claim with a TOB of 111 for the same HICN; • AND – The DME claim has a line item within the HCPCS category 03 for Orthotics AND/OR Prosthesis;**;** • AND - The DME item's From Date of Service (DOS) is within the Medicare's beneficiary's Part A admit and discharge dates; • AND - The DME item's From Date of Service (DOS) is equal to or less than two (2) days prior to the beneficiary's Part A inpatient discharge date; • AND – The beneficiaries Part A Claim Discharge Status is "01" • CWF shall pay the DME claim line items based upon the criteria listed above.											
8172.4	The Common Working File (CWF) shall create a line item IUR for a DME claim when the following conditions are true: • There is a current covered Medicare Part A inpatient claim with a TOB of 111 for a beneficiary (HICN); • AND There is a paid DME claim for the same beneficiary HICN; • AND The DME claim has a line item within the HCPCS category 03 for Orthotics AND/OR Prosthesis; • AND The DME item's From Date of Service (DOS) is within the beneficiary's Part A admit and discharge dates; • AND The DME item's From Date of Service (DOS) is greater than two (2) days prior to the beneficiary's Part A inpatient discharge date; • CWF shall prepare an IUR for the DME supplier in reference to the paid DME line items.										X	
8172.5	The Common Working File (CWF) shall create a line item IUR for a DME claim when the following conditions are true: • There is current covered Medicare Part A										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	inpatient claim with a TOB of 111 for a Medicare beneficiary HICN; • AND There is a paid DME claim for the same HICN; • AND The DME claim has a line item within the HCPCS category 03 for Orthotics **AND/OR** Prosthesis; • AND- The D**ME ite**m's From Date of Service (DOS) is within the beneficiary's Part A inpatient claim's admit and discharge dates; • AND The beneficiaries inpatient Part A claim's Discharge Status is not **"**01"; • CWF shall prepare an IUR for the DME supplier in reference to the paid DME line items.											
8172.6	**MSN Message**- The Medicare claims processing contractors shall use the appropriate MSN message as provided by CMS instruction per the MAC/Carrier manual when denying a DME claim line item by the new CWF error specified in 8172.1, 8172.2, 8172.4 and 8172.5. **CARC and RARC Codes**- The Medicare claims processing contractors shall use the appropriate CARCs and RARCs per CMS instructions in the MAC/Carrier manual when denying a DME claim rejected by the new CWF error specified in 8172.1, 8172.2, 8172.4 and 8172.5.			X						X		
8172.7	Upon receipt of the new CWF CR A/B Crossover error, VMS shall deny the claim line(s).									X		
8172.8	CWF shall forward the IURs specified in 8172.4 and 8172.5 to the DME MACs for processing.										X	
8172.9	Contractors shall process the IURs generated by CWF (as specified in 8172.4 and 8172.5).			X						X		
8172.10	DME MAC shall have override capability for a claim line upon first appeal and DME MAC determines claim should have been paid.			X						X	X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8172.11	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carlos Montoya, 410-786-6040 or carlos.montoya@cms.hhs.gov
Megan Hayden, 410-786-1970 or megan.hayden@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
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