

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1305	Date: November 6, 2013
	Change Request 8239

SUBJECT: Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider

I. SUMMARY OF CHANGES: This change request (CR) instructs the Provider Enrollment, Chain and Ownership System (PECOS) to provide a list of all providers eligible to refer to Viable Medicare Systems (VMS). This list will be used to determine if a qualified provider is listed on claims as an ordering/referring provider for a PMD. VMS shall create a denial for providers ineligible to order/refer.

EFFECTIVE DATE: April 1, 2014

IMPLEMENTATION DATE: April 7, 2014

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	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.*

One-Time Notification

Pub. 100-20

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I. GENERAL INFORMATION

A. Background: Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), added section 1834(a)(1)(E)(iv) to the Act which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861(r)(1) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as these terms are defined in section 1861(aa)(5) of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item. This purpose of this CR is to create an edit to deny any PMD (power mobility device) claims where the ordering/prescribing provider is not an eligible provider (physician, physician assistant, nurse practitioner, or clinical nurse specialist).

B. Policy:

1. Social Security Act Section 1834(a)(1)(E)

(iv) Standards for power wheelchairs.—Effective on the date of the enactment of this subparagraph in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

2. Social Security Act Section 1861(r)

(1) The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7))

3. Social Security Act Section 1861(aa)(5)

(A) The term “physician assistant” and the term “nurse practitioner” mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

(B) The term “clinical nurse specialist” means, for purposes of this title, an individual who—

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master’s degree in a defined clinical area of nursing from an accredited educational institution.

4. 42 CFR Part 410.38

(c) Power mobility devices (PMDs) —(1) Definitions. For the purposes of this paragraph, the following definitions apply:

Power mobility device means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility												
		A/B MAC			D M E M A C	F I	C A R R I E R	R H I	Shared- System Maintainers				Other	
		A	B	H H H					F I S S	M C S	V M S	C W F		
8239.1	PECOS shall provide an initial file of all physicians and non-physician providers nationally who are enrolled and are eligible to order PMD (this includes any provider with a specialty code listed in Attachment A) to VMS utilizing the existing VMS O/R file.										X		PECOS	
8239.2	PECOS shall utilize the existing VMS O/R file and the updated format. The file will consist of the following data elements. <ul style="list-style-type: none"> • First, middle and last name • NPI • Effective date (if available) • Termination date • Future Termination Date • Date of Death • CMS specialty code and description 										X		PECOS	
8239.3	PECOS shall utilize the existing naming convention and file location of the VMS O&R file. PECOS shall communicate this information to VMS if requested by VMS.											X		PECOS
8239.4	PECOS shall utilize the existing nightly VMS O&R file to transmit to VMS any newly added or updated authorized PMD ordering physicians or non-physicians.											X		EDCs, PECOS

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	F I	CARRI ER	R H I	Shared-System Maintainers				Other
		A	B	H H H					F I S S	M C S S	V M S S	C W F	
8239.5	<p>VMS shall determine if ordering provider on a DMEPOS claim for a PMD has a date of service on or after the implementation date.</p> <p>The contractor shall use the NPI, legal name, and CMS specialty code submitted to verify the physician, NP, PA, or CNS ordering is an authorized provider on the PECOS file.</p>				X						X		
8239.6	VMS shall deny a DMEPOS claim with a valid ordering provider NPI, legal name, and CMS specialty code (listed in Attachment A) with HCPCS listed in Attachment B, if the ordering provider is terminated for more than 13 months, except for those revoked. DMEPOS claims submitted with a revoked ordering provider shall be denied upon date of termination of the ordering provider.										X		
8239.7	<p>VMS shall create a line item denial for a DMEPOS claim received on or after the date of service when the following conditions are met:</p> <ul style="list-style-type: none"> • There is a current DME claim; • AND – DMEPOS supplier is billing for a PMD included in Attachment B; • AND- the PMD is not billed with CPT modifier -RA [All PMD claims for HCPCS codes specified below will bypass the edit when billed with CPT modifier -RA: Replacement of a DME item]; • AND – the ordering provider on the DMEPOS claim is not found on the PECOS file with an authorized specialty code (listed in Attachment A). 										X		
8239.8	In the limited instance of an appeal or a reopening, where payment is appropriate, the DME MAC shall have the capability to override the denial.				X						X		
8239.9	If the referring/ordering provider is not allowed to order/refer, the Medicare claims processing contractors shall use the following group codes, MSN message, CARC and RARC.				X								

Number	Requirement	Responsibility											
		A/B MAC			D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				Other
		A	B	H H H					F I S S	M C S	V M S	C W F	
	<p>For Denial- Group Code: CO</p> <p>MSN 21.6- This item or service is not covered when performed, referred or ordered by this provider.</p> <p>CARC 183- The Referring Provider is not eligible to refer the service billed.</p> <p>RARC N574 Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer.</p>												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			D M E M A C	F I	C A R R I E R	R H I	Other
		A	B	H H H					
8239.10	<p>MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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.</p>				X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): 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):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated 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.

ATTACHMENTS

Attachment A

CODE	APPROVED PHYSICIAN SPECIALTIES
01	GENERAL PRACTICE
02	GENERAL SURGERY
03	ALLERGY/IMMUNOLOGY
04	OTOLARYNGOLOGY
05	ANESTHESIOLOGY
06	CARDIOVASCULAR DISEASE (CARDIOLOGY)
07	DERMATOLOGY
08	FAMILY PRACTICE
09	INTERVENTIONAL PAIN MANAGEMENT
10	GASTROENTEROLOGY
11	INTERNAL MEDICINE
12	OSTEOPATHIC MANUPULATIVE MEDICINE
13	NEUROLOGY
14	NEUROSURGERY
16	OBSTETRICS/GYNECOLOGY
17	HOSPICE/PALLIATIVE CARE
18	OPHTHALMOLOGY
20	ORTHOPEDIC SURGERY
21	CARDIAC ELECTROPHYSIOLOGY
22	PATHOLOGY
23	SPORTS MEDICINE
24	PLASTIC AND RECONSTRUCTIVE SURGERY
25	PHYSICAL MEDICINE AND REHABILITATION
26	PSYCHIATRY
27	GERIATRIC PSYCHIATRY
28	COLORECTAL SURGERY (PROCTOLOGY)
29	PULMONARY DISEASE
30	DIAGNOSTIC RADIOLOGY
33	THORACIC SURGERY
34	UROLOGY
36	NUCLEAR MEDICINE
37	PEDIATRIC MEDICINE
38	GERIATRIC MEDICINE
39	NEPHROLOGY
40	HAND SURGERY
44	INFECTIOUS DISEASE
46	ENDOCRINOLOGY
66	RHEUMATOLOGY
72	PAIN MANAGEMENT
76	PERIPHERAL VASCULAR DISEASE

77	VASCULAR SURGERY
78	CARDIAC SURGERY
79	ADDICTION MEDICINE
81	CRITICAL CARE (INTENSIVISTS)
82	HEMATOLOGY
83	HEMATOLOGY/ONCOLOGY
84	PREVENTATIVE MEDICINE
85	MAXILLOFACIAL SURGERY
86	NEUROPSYCHIATRY
90	MEDICAL ONCOLOGY
91	SURGICAL ONCOLOGY
92	RADIATION ONCOLOGY
93	EMERGENCY MEDICINE
94	INTERVENTIONAL RADIOLOGY
98	GYNECOLOGICAL ONCOLOGY
C0	SLEEP LABORATORY/MEDICINE

CODE	APPROVED NON-PHYSICIAN SPECIALTIES
50	NURSE PRACTITIONER
89	CLINICAL NURSE SPECIALIST
97	PHYSICIAN ASSISTANT

Attachment B

List of Specified Covered PMD Items

HCPCS Code and Description

K0013: Custom Motorized/ Power Wheelchair Base

K0800-K0808 and K0812: All Power Operated Vehicles

K0813-K0891, K0898: Power Wheelchairs