CGS DME MAC

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Agenda

- New and Noteworthy Updates
- Policy and Documentation Requirements Updates
- Prior Authorization Updates
- GW Modifier Usage – Hospice Beneficiary
- myCGS Updates
- Comprehensive Error Rate Testing Data
- Targeted Probe & Educate (TPE)
- Pre-Claim Education Programs

NEW AND NOTEWORTHY UPDATES

Provider Contact Center Updates

- New authentication update when calling the Provider Contact Center
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2024/02/cope150389.html
  - JC: https://www.cgsmedicare.com/jc/pubs/news/2024/02/cope150389.html
  - Effective March 1, 2024
    - Provider National Provider Identifier (NPI)
    - Provider Transaction Access Number (PTAN)
    - The last five digits of the provider Tax Identification Number (TIN)
    - Medicare Beneficiary Identifier (MBI)
    - Beneficiary's first initial
    - Beneficiary's last name – Enter up to six letters followed "#" sign (ignore any spaces)
    - The beneficiary's date of birth

JZ Modifier for Zero Discarded Drugs & Biologicals

- For dates of service on/after July 1, 2023, suppliers must append the JZ modifier to claim line(s) for drugs and biologicals from single-dose containers administered by the supplier when there are no unused or discarded amounts
- Beginning January 1, 2024, suppliers who dispense but do not actually administer single-dose container drugs are required to report the JZ modifier on the claim
- Report the JW modifier when billing for unused and discarded amounts of drugs and biologicals and document the amount of discarded drugs in the beneficiary's record.
  - JZ modifier information in "Modifiers" section of the following LCD-related Policy Articles:
  - External Infusion Pumps
  - Intravenous Immune Globulin
- Nebulizers
- JB: https://www.cgsmedicare.com/jb/pubs/news/2023/02/cope134488.html
- CMS FAQ: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

Paper Claim Submission Errors

- Suppliers should not fax paper claims to CGS. We are unable to accept faxed claims per CMS requirements
  - Unless specific exceptions are met, claims must be submitted electronically. Some examples are:
    - You are a small provider
    - Medicare is the tertiary payor
    - You submit fewer than 10 claims per month
      - The CEDI Claims Portal provides an avenue for electronic submission of claims
      - https://www.ngscedi.com/web/ngscedi/cedi-claims-portal
  - JB: https://www.cgsmedicare.com/jb/pubs/news/2024/01/cope149898.html

Repairing DMEPOS Equipment

- Fee-for-Service Medicare will consider repairs to beneficiary-owned equipment
  - Repair means to "fix or mend and put the equipment back in good condition after damage or wear" and is not a replacement of the DMEPOS item
  - A standard written order (SWO) is not required by Medicare, but we need
    - The DMEPOS equipment remains medically necessary for the beneficiary, and,
    - Documentation the repair itself is reasonable and necessary
  - The supplier is expected to maintain record of justification for the repair, what was repaired on the item, and time spent repairing the item
  - Refer to the Supplier Manual, Chapter 5 for additional information on claim notations and billing for labor
    - JB: https://www.cgsmedicare.com/jb/pubs/pdf/chpt5.pdf

Enteral Nutrition: Rounding Rules Update

- For dates of service on or after February 6, 2024, CGS will no longer apply standard rounding rules to partial units of service (UOS) for enteral nutrition
- Suppliers should round any fraction of a UOS to the next whole number (i.e., 15.25 units should be rounded to 16)
  - https://www.cgsmedicare.com/jb/pubs/news/2024/02/cope150983.html
- Enteral Nutrition Units of Service Calculator:
  - https://www.cgsmedicare.com/jb/calculators/dutscalcent/dutscalcent.html

BCRC Updates

- Do not contact the Benefits Coordination & Recovery Center (BCRC) to create or update MSP records. MACs will update based on claim submissions
  - https://www.cgsmedicare.com/jb/pubs/news/2023/10/cope145999.html

MAC Customer Experience Survey

- Tool for CMS to measure your satisfaction with our performance
- Helps to improve processes and procedures within the MACs and CMS
- Let us know what works well and where we have room for improvement
- Leave your contact information if you'd like us to reach out to you personally

POLICY AND DOCUMENTATION REQUIREMENTS UPDATES

Seat Elevation Update

- HCPCS E2300 - “Wheelchair accessory, power seat elevation system, any type”
  - Effective through March 31, 2024
- HCPCS E2298 - “Wheelchair accessory, power seat elevation system, any type”
  - Effective as of April 1, 2024
- HCPCS code is Date of Service (DOS) driven.
  - Bill HCPCS code E2300 for DOS up to, and including, March 31, 2024
  - Bill HCPCS code E2298 for DOS April 1, 2024 forward.

Power Mobility Devices: Coding Update

- December 28, 2023 – The related Policy Article for Power Mobility Devices (A52498) revised the “No Power Options” definition
- New language: “No Power Options – A category of PWCs that is incapable of accommodating a power tilt, recline, or standing system. If a PWC can only accept power elevating leg rests and/or seat elevation, it is considered to be a No Power Option chair”
  - For Group 2, Group 3, and Group 4 no power option PWC information, removed "seat elevation" from the options the PWC is incapable of accommodating

Lymphedema Garments

- Lymphedema Compression Treatment Items (new benefit)
  - Joint coding and billing article published December 8, 2023
    - https://www.cgsmedicare.com/jb/pubs/news/2023/12/cope147943.html
- Effective for dates of service on/after January 1, 2024.
  - List of applicable HCPCS codes in the published article (approximately 80)
  - Diagnosis-driven policy (four ICD-10 diagnosis codes)
  - Three (3) day garments per body area – RUL is six months
  - Two (2) night garments per body area – RUL is two years
  - Custom fitted if applicable per the medical record
  - Accessories (zippers, lining, padding) are covered if medically necessary
  - Appropriate modifiers: LT, RT, and RA (at replacement)

External Infusion Pumps and Related Drugs

- Administration of the drug via a durable external infusion pump must be reasonable and necessary (drug is considered a supply to the DME)
  - Joint DME MAC article published January 25, 2024 https://www.cgsmedicare.com/jb/pubs/news/2024/01/cope149771a.html
- Drugs that do not have a specific HCPCS code may be billed using J7799
  - Name of drug
  - Manufacturer name
  - Dosage strength
- Pumps that do not have a specific HCPCS code may be billed using E1399
  - Description of the item, manufacturer name, product name and number, supplier price list, HCPCS of the related item

Refill Requirements Information Changes(1)

- Updated language published in applicable LCDs and the Standard Documentation Requirements Policy Article (A55426) on December 14, 2023
  - Outlined in CMS Final Rule CMS-1780-F
  - Changes effective January 1, 2024
- Please note: Continuous Glucose Monitor supply allowance (A4238 or A4239) do NOT follow refill requirements

Refill Requirements Information Changes(2)

- DME suppliers must obtain documentation of beneficiary's (or caregiver/designee) affirmative response indicating the need for the refill
  - Removed: Suppliers must document remaining quantity or functional condition of each item remaining
- Suppliers must document the beneficiary has confirmed their need for refill no sooner than 30 calendar days prior to the expected end of the current supply
  - Removed: Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date
  - Replaced "approaching exhaustion" with "expected end" language

Refill Requirements Information Changes(3)

- The refill record must include:
  - Beneficiary's name or authorized representative
  - A description of each item that is being requested
  - Documentation of affirmative response indicating a need for refill
  - Date of refill request

This information must be kept on file and available upon request

PRIOR AUTHORIZATION UPDATES

Competitive Bidding Temporary Gap

All contracts expired on December 31, 2023; the gap began January 1, 2024

- Any active DMEPOS supplier can provide the orthotics included in Round 2021:
  - Off-the-shelf spinal orthoses
  - Off-the-shelf knee orthoses

Prior Authorization Programs Exclusions

The following claim types are excluded from any prior authorization program, unless otherwise specified:

- Veterans Affairs (VA)
- Indian Health Services (IHS)
- Medicare Advantage Plans (MAPs)
- Part A and Part B Demonstrations

Prior Authorization for Orthoses

- Required nationwide as of October 10, 2022
  - Spinal orthoses: L0648 & L0650
  - Knee orthoses: L1832, L1833, L1851
- Acute situations – ST modifier
  - Practitioner-oriented modifiers KV, J4, and J5 – no longer acceptable for dates of service on/after January 1, 2024
  - Claims may be submitted with an ST modifier if there is an emergent need and the expedited prior authorization option is not appropriate
- Orthoses Prior Authorization
  https://www.cgsmedicare.com/jb/mr/orth_prior_auth.html

Other Required Authorization Programs

Prior Authorization Additional Resources	HCPCS Codes
Lower Limb Prosthetics (LLP)	L5856, L5857, L5858, L5973, L5980, L5987
Orthoses (Spinal and Knee)	L0648, L0650, L1832, L1833, L1851
Power Mobility Devices (PMD)	K0800-K0802, K0806-K0808, K0813-K0829, K0835-K0843, K0848-K0864
Power Mobility Devices (PMD) Accessories – Voluntary Prior Authorization	E0950, E0955, E1002-E1010, E1012, E1029, E1030, E2310-E2313, E2321-E2330, E2351, E2373, E2377, E2601-E2608, E2611-E2616, E2620-E2625, K0020, and K0195
Pressure Reducing Support Surfaces (PRSS)	E0193 E0277, E0371, E0372, E0373

Dedicate page on the CGS Website in the Medical Review section:
https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html

Retroactive Coverage and Prior Authorization (PA)

- When prior authorization is a condition of payment for an item
- Beneficiaries with retroactive Medicare eligibility status must have a PA Request (PAR) submitted on their behalf to the DME MAC for payment reimbursement
  - Suppliers should:
    - Indicate that the item has delivered
    - Indicate Medicare coverage is retroactive
    - Submit all necessary PAR documentation to support the medical necessity of the item
- Claims submitted without first going through the PA process will be denied
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/Operational-Guide-for-DMEPOS-PA-current.pdf

Prior Authorization Questions

Prior Authorization (PA)

- JB Inquiries Email Box
  JB.PA.INQUIRY.MAILBOX@cgsadmin.com
  - Available to suppliers for questions related to Prior Authorization decisions
  - Please refrain from submitting duplicate emails
  - Please do not submit PHI through email – UTN is acceptable
  - Not intended for Non-Prior Authorization related issues
    - i.e., Redetermination, Claims, Written Reopenings, TPE, etc.

GW MODIFIER USAGE

DMEPOS Claims while Beneficiary is in Hospice

- Services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice
- A beneficiary receives, as part of the information on Hospice coverage, notification of the individual's (or representative's) right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice

DMEPOS Claims while Beneficiary is in Hospice, Continued

- When billing for conditions unrelated to the individual's terminal illness:
  - Append the GW modifier to the claim if the condition is listed on the election statement addendum
  - Addendum must be available upon request https://www.cms.gov/files/document/model-hospice-election-statement-addendum-modified-july-2020.pdf
- Medicare Benefit Policy Manual, Chapter 9, Section 20.2.1.2
  - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf

Hospice Addendum Statement

- For Hospice elections beginning on or after October 1, 2020, when the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement.
- All elements must be present:
  - Diagnoses related to the terminal illness and related conditions
  - Diagnoses unrelated to the terminal illness and related conditions
  - Non-covered items, services, and drugs determined by hospice as not related to the terminal illness and related conditions
  - Must be signed by the beneficiary, or their representative, and a witness

Hospice and GW Modifier Updates

Hospice and GW Modifier

- Pre-payment TPE claim reviews
- Things to keep in mind when appending the GW modifier:
  - Assure the GW modifier is appropriate
  - Work with the hospice provider and request the Hospice Election Statement Addendum
    - https://www.cms.gov/files/document/model-hospice-election-statement-addendum-july-2021.pdf
    - CGS "To The Point" Video: https://www.cgsmedicare.com/jb/education/point/hospice.html
  - CMS Benefit Policy Manual (IOM 100-2), Chapter 9, Section 20.2.1.2
    - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf
  - OIG Report
    - https://oig.hhs.gov/oas/reports/region9/92003026.pdf
  - CGS Video Education
    - https://www.cgsmedicare.com/jb/education/video/vid_hospicegw.html

MYCGS DME PORTAL UPDATES

Recent myCGS Updates

- Additional Home Health information
  - Episode and billing dates and 16-month date span
- Beneficiary Eligibility/Medicare Secondary Payer (MSP) Screen
  - Ongoing Responsibility Medicals (ORM) field
    - This field will populate when a beneficiary's MSP record includes an ORM value
  - More Medicare as a Secondary Payer (MSP) Information
    - Group number, date of loss, maintenance date, source/code description, patient relationship code/description
    - 16-month time span for date of service entered in the portal

myCGS Updates(1)

- Unlock your own account without having to call into our Customer Support Center
- "Prior Authorization" status available within minutes
  - Detailed Prior Authorization Status
    - Received, Pending, Affirmed, Non-Affirmed, and Rejected
- "Same/Similar" screen
  - Search and Exit buttons added to the top of the page
- Updates to the "Hospice" screen
- "Ordering/Referring Physician" screen has been updated
- Added IVR Medicare Beneficiary Identifier (MBI) converter

myCGS Updates(2)

- myCGS version 8.0 included PASS!
  - Prior Authorization Smart Submission
    - Submit the information you need for prior authorization
    - Reduce the possibility of a rejection
    - Step-by-step approach to completing a prior authorization
    - “Backtrack” without losing information
    - Applicable for all HCPCS codes that require prior authorization
    - Real-time editing of submission

myCGS 8.2 Updates

- New myCGS features in version 8.2:
  - Updated Prior Authorization Smart Submission (PASS) for Lower Limb Prosthetics so that multiple HCPCS codes can be selected for submission on one request
  - Updated PASS for Orthotics so that up to three HCPCS codes can be selected for submission on one request
  - The "Helpful Links" page (found in the News & Information menu) has been updated to include links to other websites that suppliers may find useful (such as CEDI, PDAC, CERT, etc.)
- Additionally, the release made fixes or corrections to some minor issues
  - Updated some incorrect hyperlinks
  - Corrected an issue with some Reopening statuses not displaying accurately

https://www.cms.gov/https/wwwcmsgov/data-research/monitoring-programs/improper-payment-measurement-programs/2023-medicare-fee-service-supplemental-improper-payment-data

COMPREHENSIVE ERROR RATE TESTING (CERT) DATA

Error Rates Per Type - CERT 2023 Report

FFS Type	Claims Sampled	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate
Part A (Exc. Hospitals)	9,736	8,506	$183.4	$14.2	7.8%
Part A (Hospital)	14,863	8,753	$121.4	$4.1	3.4%
Part B	12,303	12,001	$109.6	$11.0	10.0%
DMEPOS	8,408	8,248	$8.7	$1.9	22.5%
Total	45,310	37,508	$423.0	$31.2	7.4

*Amounts are reflected in billions of dollars.

Error Rates DMEPOS Type - CERT 2023 Report

Policy Group	Error Rate	No Documents	Insufficient Documents	Medical Necessity	Other
Orthopedic Footwear	100.0%	9.3%	84.5%	0.9%	5.3%
Oral Anti-Cancer Drugs	84.0%	0.0%	7.3%	0.0%	92.7%
Pneumatic Compression	78.9%	0.0%	55.1%	41.2%	3.7%
Lenses	70.7%	2.5%	43.1%	27.2%	27.2%
Surgical Dressings	62.1%	44.1%	47.8%	1.7%	5.0%
Diabetic Shoes	51.4%	0.0%	84.6%	0.0%	15.4%
Commodes/Bed Pans	47.7%	0.0%	52.9%	0.0%	47.1%
Manual Wheelchairs	42.6%	0.0%	77.8%	0.0%	22.2%

Error Rates DMEPOS Payment - CERT 2023 Report

Policy Group	Claims Reviewed	Error Rate	Projected Improper Payments
Surgical Dressings	370	62.1%	$262.6 Million
CPAP	1,034	15.0%	$157.5 Million
Ventilators	241	24.3%	$135.9 Million
Urological Supplies	255	28.1%	$116.6 Million
Glucose Monitors	791	13.5%	$103.2 Million
Lower Limb Orthoses	432	36.6%	$92.0 Million
Parenteral Nutrition	295	37.1%	$86.4 Million
Oxygen	480	11.4%	$82.7 Million

Michigan FFS Projected Improper Payment: DMEPOS Only- CERT 2023 Report

	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
All States	8,248	$1,947.5 B	22.5%
Michigan	**250**	**$111.3 M**	**42.4%**

TARGETED PROBE & EDUCATE (TPE)

Dr. Sunil Lalla, MD, FACS, CPC
Medical Director Jurisdiction B, DMD

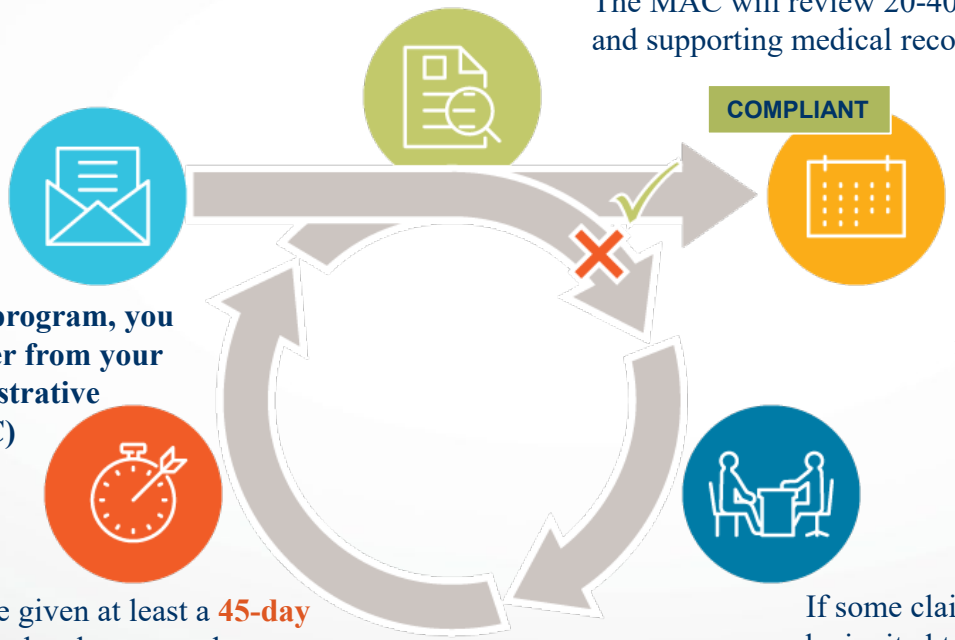
Sunil Lalla, MD, FACS, CPC
Chief Medical Officer, CGS Administrators, LLC
Surgeon
6 years as Contractor Medical Director (5 A/B MAC, 1 DME)

- Dr. Sunil Lalla has been appointed the JB Executive Medical Director to succeed Dr. Stacey Brennan who retired January 2023
  - Dr. Lalla has over 25 years of experience as a clinical surgeon. He is board certified and twice recertified by the American Board of Surgery and is a Fellow of the American College of Surgeons
  - Dr. Lalla also has extensive experience as an A/B Medical Director with another MAC prior to joining CGS Administrators, LLC
  - Dr. Lalla has been in the role of the CGS Research Medical Director for JB and JC since September 2021

Targeted Probe & Educate

- TPE goal is to improve claims payment error rate
- Reduce volume of appeals
- Existing data analysis determines suppliers to review
- High claim error rates or unusual billing practices
- Claims with greatest financial risk to Medicare
- Initial TPE review consists of 10 claims
- Review of 20-40 claims, if errors are found in the initial 10
- One-on-one education to address errors
- Up to three rounds of probe reviews
- JB: https://www.cgsmedicare.com/jb/mr/tpe.html

How Does TPE Work



If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC)

The MAC will review 20-40 of your claims and supporting medical records

If compliant, you will not be reviewed again for at least **1 year** on the selected topic

You will be given at least a **45-day** period to make changes and improve

If some claims are denied, you will be invited to a one-on-one education session

MICHIGAN ASSOCIATION FOR Home Care

Provider Selection

- Based upon internal data analysis of provider billing practices
- Comparative reports of code utilization rates
- Comprehensive Error Rate Testing (CERT) reports
- CMS directives and Office Inspector General (OIG) recommendations
- Referral from a RAC, UPIC, or Government Accountability Office
- Providers based on:
  - Historic high claim denials
  - Outlying billing practices
  - Potential risk of harming the Medicare Trust Fund

TPE Rounds

Round 1

- Notified via letter
- 20-40 claims reviewed
- Notified of focus topic
- Can receive education during the probe

Round 2

- Follows post-probe education from Round 1
- Did not meet required guidelines
- Claims selected for review – 45 day waiting period
- Can receive education during the probe

Round 3

- Follows post-probe education from Round 2
- Did not meet required guidelines
- Claims selected for review- 45 day waiting period
- Can receive education during the probe

TPE Quarterly Report

- 10 Claim Pilot – 8.5% Successfully Passed
- Round 1 – 38.4% Successfully Achieved Exclusion
- Round 2 – 36.5% Successfully Achieved Exclusion
- Round 3 – 34.7% Successfully Achieved Exclusion

TPE Quarterly Report 1

Description	Error Rate (October – December 31 2023)	HCPCS
Ankle-Foot Orthoses (AFO)	36.59%	L1900-L1990, L2000, L2005, L2010-L2136, L4350-L4387, L4396-L4397 and L4631
Blood Glucose Test Strips	38.31%	A4253
Commodes	40.53%	E0163 and E0165
Continuous Airway Positive Pressure (CPAP)	36.33%	E0601
Enteral Nutrition	10.53%	B4035
Hospital Beds	10.20%	E0260, E0261, and E0303
Immunosuppressive Drugs	4.35%	J7503, J7507, J7518, J7520, and J7527
Knee Orthoses	65.22%	L1832, L1833, L1843, L1844, L1845, L1851, L1852, and L2397
Manual Wheelchairs	44.13%	K0001-K0004
Nebulizers	30.65%	J7605, J7606, J7613, J7620 and J7626
Oxygen and Oxygen Equipment	25.86%	E0424, E0439, E1390 and E1391
Spinal Orthoses	56.99%	L0450-L0651
Surgical Dressings	39.81%	A6010, A6021, A6196-A6199, A6203, A6209-A6212, A6231-A6233, A6234-A6241, A6242-A6248, and A6251-A6256
Surgical Dressings – GW Modifier	100.00%	A4452, A6213, A6219, A6222 and A6446
Therapeutic Shoes for Persons with Diabetes (TSPD)	45.41%	A5500, A5512, and A5513
Urological Supplies	30.81%	A4316, A4351, A4352, A4353, and A4355
Urological Supplies – GW Modifier	100%	A4316, A4351, A4352, A4353 and A4355

Possible CMS Penalties (42 CFR § 424.535)

- Additional rounds of TPE
- 100% prepayment review
- Extrapolation (PIM Chapter
- Referral to RAC
- Referral for revocation
- Medicare privileges revoked

Provider Responsibility

- Respond promptly to any letter offering education
- Responsible for sending all requested documents
  - Separate each claim with a coversheet
- Ask questions
  - Interact with TPE education sessions
  - Through email
- Consider who will attend education session(s)
- Can request education at any time

Tips & Recommendations

- Thoroughly review and follow directions on letter request
  - Obtain the requested documentation
    - Must be legible and signed
    - Do not highlight information
    - Do not combine multiple requests into a single response
    - Only send documentation once per ADR letter
    - Respond within the timeframe specified
    - Respond to proper entity (CERT, UPIC, RAC, etc.)
- Always place the ADR letter as the cover sheet ON TOP of your documentation

Tips & Recommendations$_1$

- Seek clarification
- Have a designated contact person
  - Email and/or direct phone number
  - Avoid providing customer service lines, fax numbers, service operators, etc.
- Verify address in PECOS – notification letters are sent to the "other" address
- Respond to letter offering education
- Utilize checklists
  - https://www.cgsmedicare.com/jb/mr/documentation_checklists.html

PRE-CLAIM EDUCATION PROGRAMS

MICHIGAN ASSOCIATION FOR Home Care

CGS Connect® Program Educational Feedback

- Pre-review of your documentation to provide educational feedback
  - **Clinical Reviews - Voluntary Program**
  - **Estimated MR Response Time: 10-15 Days**
- Jurisdiction B: https://www.cgsmedicare.com/jb/mr/cgsconnect.html

Ankle Foot Orthosis & Knee Ankle Foot Orthosis L1902, L1906, L1930, L1971, L4360, L4361, L4396, L4397	Commodes E0163 and E0165	Continuous Glucose Monitors (CGMs) E2103, A4239	Continuous Positive Airway Pressure (CPAP) E0601	CPAP Accessories A7030 and A7034
Enteral Nutrition B4035	External Infusion Drugs/Pumps J2260, J1559, J3285	Glucose Testing Supplies A4253, A4256, A4258, A4259	Hospital Beds E0260, E0261, E0294, E0301, E0303	Immunosuppressive Drugs J7507, J7518
Manual Wheelchairs K0001, K0002, K0003, K0004	Nebulizer and Related Drugs J7605, J7606, J7686	Oxygen E1390 *initial beneficiary claims only	Respiratory Assist Devices E0470, E0471	Spinal Orthosis L0450-L0647 and L0651
Surgical Dressings A6196, A6197, A6021, A6212, A6010	Therapeutic Shoes for Persons with Diabetes A5500 *Inserts provided with the A5500 will be included in the review.*	Urological Supplies A4351, A4352, A4353		

Advanced Determination of Medicare Coverage (ADMC)

- Advance Determination of Medicare Coverage (ADMC) is a voluntary program that allows Suppliers and Beneficiaries to request prior approval of "eligible" items before delivery of the items to the beneficiary. At this time, only customized wheelchairs (manual and power) are eligible for ADMC. Approval applies to the medical necessity of the item and does not guarantee that the claim will be paid. Other claim edits, such as Medicare eligibility, could cause the claim to deny even though ADMC approved the item.

HCPCS Code	Type of Base
E1161	Manual adult size wheelchair, includes tilt in space
E1231 – E1234	Manual pediatric size wheelchair, includes tilt in space
K0005	Manual adult size wheelchair, ultra lightweight
K0008	Custom manual wheelchair/base
K0009	Manual adult size wheelchair, not otherwise classified
K0013	Custom Motorized/Power Wheelchair Base
K0890 – K0891	Power pediatric size wheelchair, group 5 – Single or Multiple power options

- When a particular wheelchair base is eligible for ADMC, all wheelchair options and accessories ordered by the physician for that patient along with the base HCPCS code will be eligible for ADMC.

ADMC Rejections

- ADMC requests are reviewed to determine whether or not they meet the requirements for ADMC requests.
  - A rejection is NOT a denial.
- If the request is rejected then a letter will be mailed to the supplier and the beneficiary within 30 days explaining why the request was rejected. Another request may be resubmitted along with any additional and/or corrected documentation.
  - There is no time limit for rejections.

ADMC 2nd Submissions

- While a negative ADMC decision cannot be appealed, an ADMC request can be resubmitted if the wheelchair base is denied and additional medical documentation is obtained.
  - ADMC requests may only be resubmitted once during the six-month period following a negative determination.
    - If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories or any additional accessories.
- If you provide a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted.
  - If new information is provided with the claim, coverage will be considered.
  - If the claim is denied, it may be appealed through the usual process.
- Determination within 30 calendar days
  - Clinician will provide determination to supplier and beneficiary in writing.
    - If negative determination, clinician will provide explanations.
- Affirmative ADMC valid for 6 months following the date of the determination.
- For more information: https://www.cgsmedicare.com/jb/mr/admc.html

QUESTIONS AND ANSWERS

The End