Welcome to Today's Lunch and Learn with Highmark

The program will begin at noon. You will hear silence until then. Please take this opportunity to check your connections. Use the chat to type any questions or issues.

Lunch and Learn with Highmark Professional Education
CME/CEU Webinar Series

Demystifying DMEPOS
(Durable Medical Equipment, Prosthetics, Orthotics, and Supplies)

November 14, 2023

Anne Lacienski, CPMA
Jayme Patterson, CPC
Cynthia Scott, CPC
Sherry Roedersheimer, COC, CPC, CPMA

Presented by:

HIGHMARK WHOLECARE

Learning Objectives

In this presentation, the attendee will learn:

- What constitutes DMEPOS
- Standard DME coding and documentation guidelines
- Standard equipment protocol with a focus on glucose monitors
- How to identify common areas of Fraud, Waste, and Abuse
- How/where to report Fraud, Waste, and Abuse

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This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Disclosures

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The following presenters disclose no conflicts

Kyle Wilson; Anne Lacienski, CPMA; Cynthia Scott, CPC; Jayme Patterson, CPC; and Sherry Roedersheimer, COC, CPC, CPMA

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- **Text code YEHLEM to 412-301-9919;** you MUST text by the end of the day today to receive credit!
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  - Click on the my activities tab
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Questions?

Email ahncme@ahn.org

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Today's Presenters

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Agenda

Agenda Item	Presenter
What is DMEPOS?	Anne Lacienski, CPMA
Importance of Medical Record Documentation when Ordering and Providing DMEPOS to Patients	Jayme Patterson, CPC
Ordering Glucose Monitors and Supplies for Your Patients	Cynthia Scott, CPC
Caution – Learn Common Areas of Potential Fraud, Waste, and Abuse	Sherry Roedersheimer, COC, CPC, CPMA
Reporting Potential Fraud, Waste, and/or Abuse	Sherry Roedersheimer, COC, CPC, CPMA

What is DMEPOS?

November 2023

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DMEPOS/DME

Durable Medical Equipment Prosthetics,
Orthotics and Supplies.

Definition

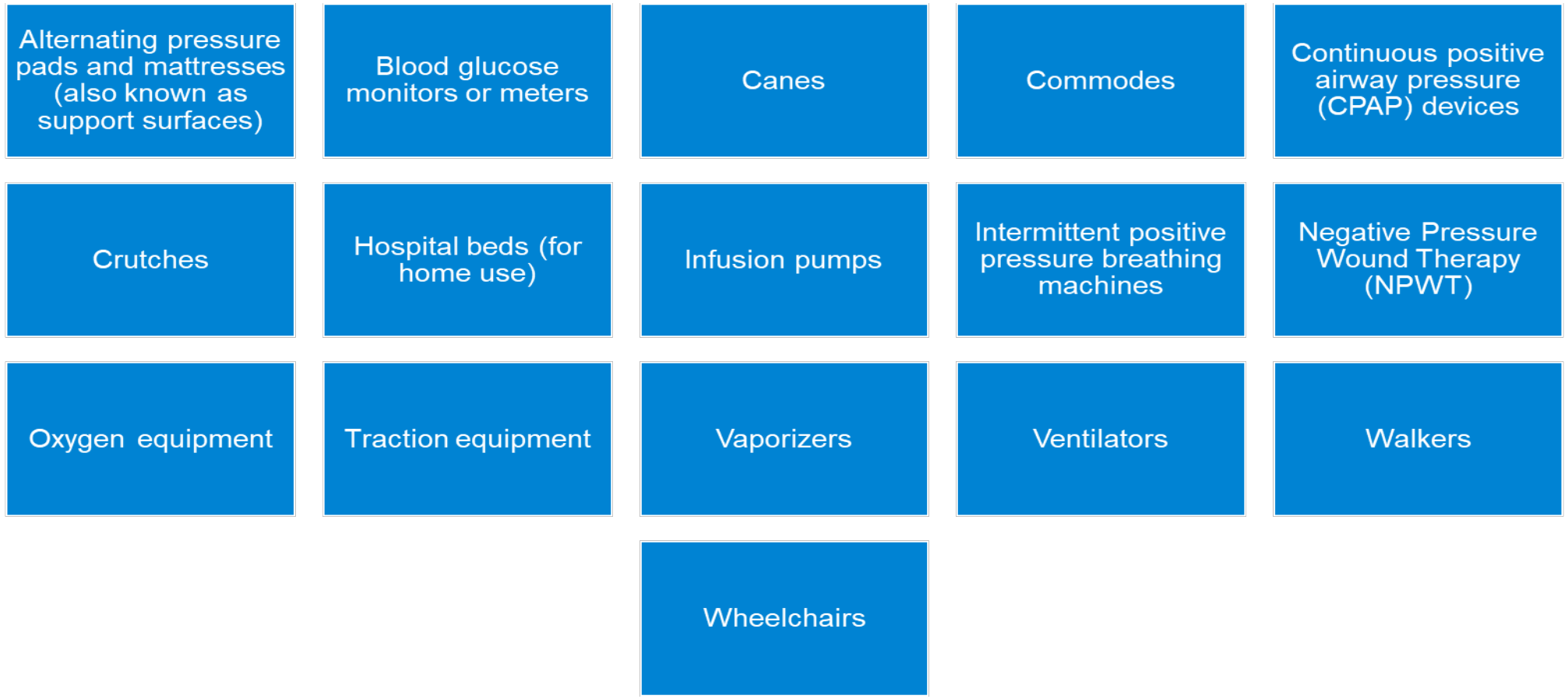
The Center for Medicaid and Medicare Services (CMS) 42 CFR, 414.202, DMEPOS is defined as equipment which: “(a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. For items to be considered DME, all requirements of the definition must be met.”

DMEPOS Codes

DMEPOS utilize the HCPCS level II code set. All DMEPOS codes start with a letter followed by a number.

Example. L1830 – Knee orthosis. Immobilizer canvas longitudinal, prefabricated, off the shelf.

Examples of DMEPOS Items by Category



Importance of Medical Record Documentation when Ordering and Providing DMEPOS to Patients

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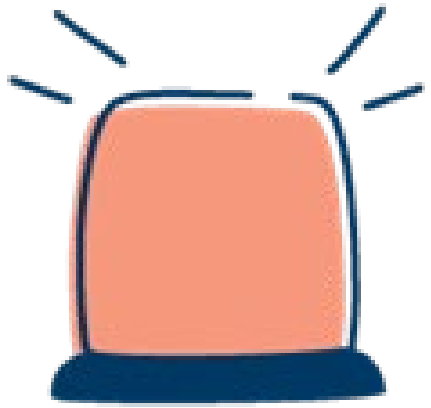
Providers: It is your Responsibility to Assist your DMEPOS Suppliers



Tips:

- DMEPOS suppliers are your partners in caring for your patient(s).
- Suppliers will not receive payment from Medicare for the items that are ordered if you do not provide information from your medical records when it is requested.
- In addition, not providing sufficient information from the medical records supporting the item(s) that you ordered, may result in your patients having to pay for the items out-of-pocket.
- When promptly furnishing information from the medical records requested this helps your DMEPOS supplier(s) to be able to provide good service to your patient(s).

Ordering DME, Prosthetics, Orthotics, and Supplies (DMEPOS)

- **Who can order DMEPOS?**
- Physician (MD or DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Clinical Nurse Specialist (CNS)

- **To qualify as an ordering provider, you must:**
  - Have an individual National Provider Identifier (NPI)
  - Be enrolled in Medicare in either an "approved" or an "opt-out" status
  - Be of an eligible specialty type
  - https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/ordering-certifying#eligible-specialty-types
- Items and services you can order and certify will depend on your specialty type. Always remember to contact your MAC if you have questions about what you can order and certify.
  - https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf

Documentation Plays a Key Role within the Beneficiary's Medical Record

A patient's medical record is extremely important to support and confirm accurate claim payment. Medical records should always be complete and legible. DME documentation is used to substantiate the need for the item, quantity ordered/supplied, and frequency within the medical record. The record documentation is used to support the medical necessity of the DMEPOS item.

The medical record is not limited to treating practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive).

Documentation requirements are assembled from Statutes, Code of Federal Regulations, Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs), CMS rulings and sub-regulatory guidance (CMS manuals), and DME MAC publications.

Orders – Standard Written Order (SWO)

A SWO must contain all the following elements:

- ✓ Beneficiary name or Medicare Beneficiary Identifier (MBI);
- ✓ General description of the item. The description can be either a general description (e.g., wheelchair or hospital bed), a brand name/model number, a HCPCS code, or a HCPCS code narrative;
- ✓ For equipment – In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories, or additional features that are separately billed or require an upgraded code (List each separately);
- ✓ For supplies – In addition to the description of the base item, the SWO may include all concurrently ordered supplies that are separately billed. Note: If such items are not concurrently ordered, they nonetheless require an order for payment purposes;
- ✓ Quantity to be dispensed, if applicable;
- ✓ Order Date;
- ✓ Treating Practitioner Name or National Provider Identifier (NPI); and
- ✓ Treating Practitioner Signature.
- ❖ In those limited instances in which the treating practitioner is also the supplier and is permitted to furnish specific items of DMEPOS and fulfill the role of the supplier in accordance with any applicable laws and policies, a SWO is not required. However, the medical record must still contain all the required SWO elements.

Written Orders Prior to Delivery (WOPD)

- All DMEPOS items require a written order/prescription from the treating practitioner to be communicated to the supplier before submitting a claim for Medicare payment.

- CMS may suspend the face-to-face encounter and written order prior to delivery requirements generally, or for a particular item or items, at any time and without creating a new rule – except for items included on the Master List (PDF). Items appearing on the Required List are subject to the face-to-face encounter and written order prior to delivery requirements. Please refer to the Standard Documentation Requirements Article (A55426) for additional information.

- DMEPOS items (non-power mobility device codes) added to the required face-to-face encounter and written order prior to delivery list
  - https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf

Requirements of New Orders

A new order is required:

- For all claims for purchases or initial rentals;
- If there is a change in the DMEPOS order/prescription (e.g., quantity);
- On a regular basis (even if there is no change in the order/prescription) only if it is so specified in the documentation section of a particular medical policy;
- When an item is replaced;
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier.

Face-To-Face Encounter

- A face-to-face encounter means an in-person or telehealth encounter between the treating practitioner and the beneficiary. The face-to-face encounter must be used for the purpose of gathering subjective and objective information associated with diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered. Telehealth encounters used to satisfy the face-to-face requirement must meet the requirements of 42 CFR §§ 410.78 and 414.65 for purposes of DMEPOS coverage.
- **Master List of DMEPOS Items potentially subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements.**
  - https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf

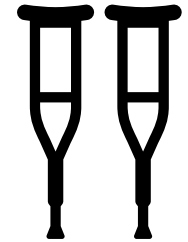
Continued Medical Need

Any of the following may serve as documentation justifying continued medical need:

- ✓ A recent order/prescription by the **treating practitioner** for refills of supplies;
- ✓ A recent order/prescription by the **treating practitioner** for repairs;
- ✓ A recent change in an order/prescription;
- ✓ A properly completed CMN or DIF obtained prior to DOS 01/01/2023, with an appropriate length of need specified; and
- ✓ 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.

❖ **Always refer to the LCD-related Policy Articles for clarification regarding exceptions to ongoing justification for continued medical need.**

Repairs & Replacement for DME Items



Repairs:

- A new CMN and/or **treating practitioner's** order is not needed for repairs.
- In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base item initially, medical necessity for the base item has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:
  - The **treating practitioner** must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and,
  - Either the **treating practitioner** or the supplier must document that the repair itself is reasonable and necessary.

Replacement:

- A treating practitioner's order and/or new CMN (prior to DOS 01/01/2023), when required, is needed to reaffirm the medical necessity for replacement of an item.
- Medicare payment may be made for the replacement of prosthetic devices, which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if a **treating practitioner** determines that the replacement device, or replacement part of such a device, is necessary.

Certificate of Medical Necessity (CMN) & DME Information Form (DIF)

- **Providers** and **Suppliers** no longer need to submit Certificate of Medical Necessity (CMN) or DME Information Form (DIF) for services rendered on or after January 1, 2023.
  - For claims with dates of service on or after January 1, 2023 – providers and suppliers no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached with be rejected and returned to the provider or supplier.
  - For claims with dates of service prior to January 1, 2023 – processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim or be on file with a previous claim.

For claims with a date of service on or after January 1, 2023, a CMN cannot be used as the Standard Written Order (SWO) or Written Order Prior to Delivery (WOPD). CMNs that were signed and dated prior to January 1, 2023, are valid for 12 months and may continue to be utilized as the SWO/WOPD until the CMN expires.

The forms that were eliminated are as follows:

CMN

- 484 Oxygen
- 846 Pneumatic Compression Devices
- 847 Osteogenesis Stimulators
- 848 Transcutaneous Electrical Nerve Stimulators
- 849 Seat Lift Mechanisms
- 854 Section C Continuation Form

DIF

- 10125 External Infusion Pumps
- 10126 Enteral and Parenteral Nutrition

Resources

- CMS Internet Only Manual (IOM), Publication 100-08, Program Integrity Manual, Chapter 5, Section 5.5

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf

CMN Completion Tips

Section A: Supplier

The “Initial Date” found in Section A of the CMN should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the “Initial Date” would be the date of the order.

Section B: Physician

Physician assistants may provide the dispensing order and write and sign the detailed written order if they satisfy all the following requirements.
1. They meet the definition of physician assistant found in §1861(aa)(5)(A) of the Act; 2. They are treating the beneficiary for the condition for which the item is needed; 3. They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy; 4. They have their NPI; and 5. They are permitted to perform services in accordance with State Law. Physician assistants may complete section B and sign section D of a CMN if they meet all the criteria described above.

Section C: Supplier

The CMN can serve as the physician’s detailed written order if the narrative description in Section C is sufficiently detailed. This would include quantities needed and frequency of replacement for accessories and supplies. For items requiring both a CMN and a written order prior to delivery (e.g. seat lift mechanisms) suppliers may utilize a completed and physician signed CMN for this purpose. Otherwise, a separate order in addition to a subsequently completed and signed CMN is necessary.

Section D: Physician

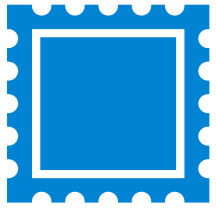
The “Signature Date” is the date the physician signed and dated Section D of the CMN. This date might not be the same as the “Initial Date,” since the “Signature Date” must indicate when the physician signed Section D of the CMN.

Note: A nurse practitioner or physician assistant may complete Section B and sign Section D of a CMN if they meet all the criteria described above for signing orders.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf

Tips for Providers regarding Medical Record Authentication

Healthcare providers ordering or documenting the medical necessity for items or services received by Medicare beneficiaries must be identifiable.

All signatures must comply with the CMS signature requirements outlined in the Medicare Program Integrity Manual (CMS Pub. 100-08), Chapter 3, Section 3.3.2.4.



Remember: Signature and date stamps are not allowed

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf

Ordering Glucose Monitors and Supplies for Your Patients

November 2023

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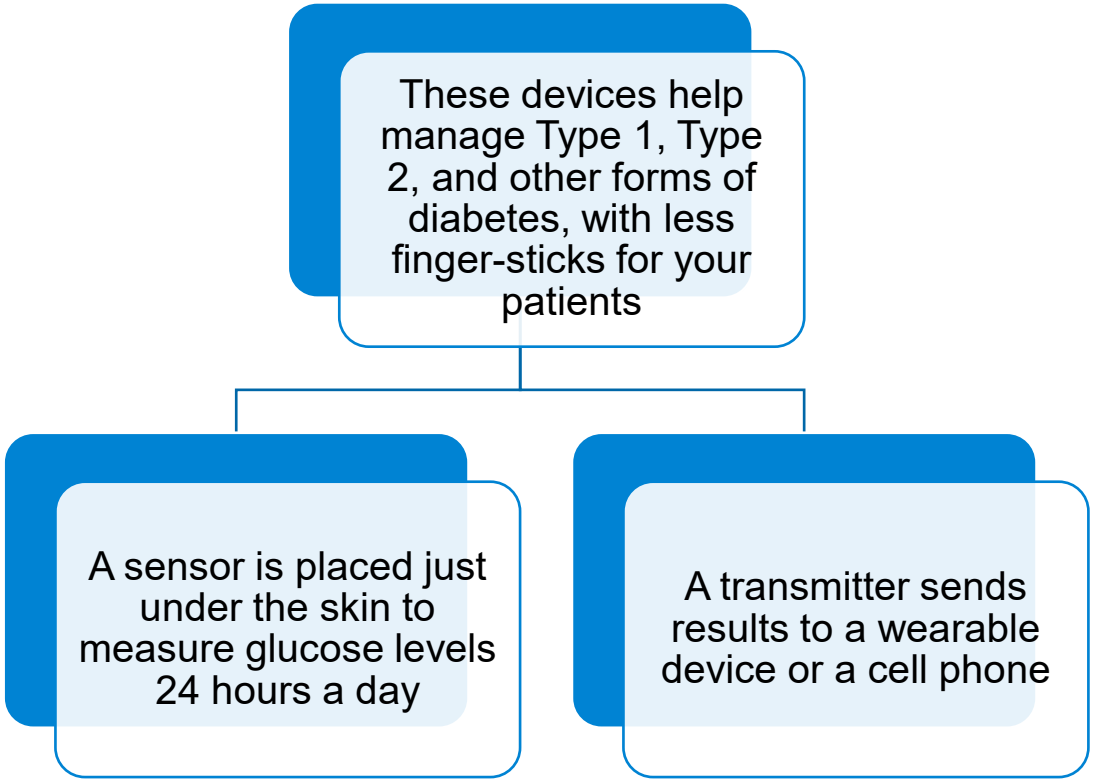
Glucose Monitors and Supplies



Continuous Glucose Monitors (CGM)

- A prescription is required for these devices
- May be used by adults and children
- Typically covered under the DME or Pharmacy benefit and may require prior authorization
  - Check payer policy or LCD
- All CGM's estimate blood glucose levels; however, the information and displays may be different

1. Real time CGM devices send and display information to a smartphone or receiver automatically.
2. Intermittent-scan CGM devices monitor estimate glucose levels continuously however, these need scanned with a separate smartphone or receiver every few hours to view the information
3. Another type collects the blood glucose level so the doctor may download and review it at another time.

Differences in Devices

- Sensor placement
- Sensor replacement times
- Warm-up times
- Adjustable program settings
- Calibration by finger-sticks with the standard blood glucose monitor

CGM Features

- Some CGM's may pair with apps that:
  - Track food and beverages
  - Track physical activity and medications
  - Monitor glucose level trends
  - Sound alarms for low/high glucose levels

Billing

Per CMS:

1. For any item to be covered it must be eligible for a defined CMS benefit category
2. Must be reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member
3. Meet all other applicable CMS statutory and regulatory requirements

Billing Cont.

It was determined on February 28, 2022, by CMS that both adjunctive and non-adjunctive CGMs are classified as DME

Adjunctive CGM-requires users to verify their glucose levels/trends displayed on a CGM with a blood glucose monitor (BGM) prior to treatment decisions. (HCPCS code A4238)

test results (HCPCS code A4239) **Non-adjunctive** CGM are used to make treatment decisions without a stand-alone BGM to confirm

- The supply allowance for **adjunctive** CGMs (A4238) supplies used with a CGM system encompasses all items necessary for the use of the device and includes but is not limited to, CGM sensors and transmitters. Billing of CGM sensors and transmitters separately will be denied as **unbundling**. This does **NOT** include a home BGM and related testing supplies (HCPCS codes E0607, E2100, E2101, A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259). These codes may be billed separately with A4238.
- The supply allowance for **non-adjunctive** CGMs (A4239) includes a home BGM, test strips, lancets, lancing device, calibration solution, and batteries. Any accessories or supplies billed separately will be denied as **unbundling**.

Billing Cont.

- If the patient uses a stand-alone insulin infusion pump or receiver classified as DME to display glucose data, coverage of a CGM system supply allowance is available
- CMS coverage is available for a CGM supply allowance if a non-DME device such as a smartphone, tablet, laptop, etc., is used in conjunction with the durable CGM receiver (E2102 & E2103)
- If a DME receiver or insulin infusion pump to display CGM data is not used, this would not be covered by CMS
- CMS does not cover smart devices as they do not meet the definition of DME. These claims would be billed with HCPCS code A9270 (non-covered item or service)

Non-Covered Items

- Alcohol (A4244 & A4245)
- Peroxide (A4244)
- Betadine (A4246 & A4247)
- Hexachlorophene (A4246 & A4247)
- Urine test reagent strips or tablets (A4250)
- Reflectance colorimeter devices
- Disposable Home BGM including testing strips (A9275)
- Glucose monitors not designed for home use (A9270)

Modifiers

CGM devices (E2102 & E2103), BGM monitors (E0607, E2100, E2101), supply allowance (A4238 & A4239), and related supplies (A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259) the following modifiers must be added to the codes on each claim submitted:

- **KX**-patient is insulin treated (not used for a patient who is exclusively treated with oral hypoglycemic agents)
- **KS**-patient is non-insulin treated

Modifier **CG** is appended for an adjunctive CGM (E2102) incorporated into an insulin pump and supply allowance (A4238) ONLY if all initial CGM coverage criteria in the Glucose Monitors LCD and coverage criteria for an insulin infusion pump as outlined in External Infusion Pumps LCD (L33794) are met. If all coverage criteria are NOT met, do NOT append the CG modifier.

Modifier **CG** is appended for initial coverage of non-adjunctive CGM devices (E2103) and the supply allowance (A4239) if all CGM coverage criteria in the Glucose Monitors LCD are met. If all coverage criteria are NOT met, do NOT append the CG modifier.

Requirements

Face-to-Face encounter

- The medical record must contain sufficient information to state the patient has diabetes mellitus and the patient or caregiver has received the appropriate training for the device
- The CGM must be prescribed in accordance with FDA indications
- The CGM is being prescribed to improve glycemic control for a patient that is insulin treated or has a history of problematic hypoglycemia

Written Order Prior to Delivery (WOPD)

Caution – Learn Common Areas of Potential Fraud, Waste, and Abuse

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Definitions

Fraud
is defined by state and federal laws and typically occurs when a provider or consumer intentionally submits, or causes someone else to submit, false or misleading information to a health insurance company for the purpose of receiving payments that an individual or entity is not eligible to receive.

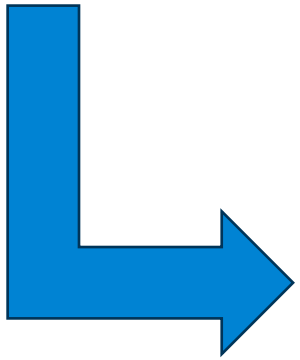
Waste
is defined as the overutilization of professional medical services or the misuse of resources by a health care provider.

Abuse
is defined as incidents or practices of providers, physicians, or suppliers of services and equipment that are inconsistent with accepted sound medical, business, or fiscal practices.

Definitions

Material Misrepresentation

When a provider submits claims to Highmark for reimbursement, the provider is contractually obligated to ensure that the information in the claim accurately reflects the services performed as documented in the provider's records. Claims that do not accurately reflect the services performed are misrepresentations; when a misrepresentation results in an overpayment to the provider, it is a material misrepresentation.



Because the provider is contractually obligated to submit claims that accurately reflect the services performed, Highmark may retroactively adjust payments to reflect the services actually performed following a review of the provider's records or receipt of other information that indicates a claim materially misrepresents the services performed. Highmark may retroactively adjust payments in these circumstances and seek recoupment even where there is no evidence that the provider or entity intentionally submitted claims containing misrepresentations.

Financial Investigations and Provider Review (FIPR)

- Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality health care by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of health care insurance fraud, waste, abuse, or material misrepresentation ("FWAM").
- In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider FWAM. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential health care FWAM. When necessary, FIPR takes internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers, or members.

Common Areas of Potential FWA

Watch out for red flags that could indicate potential fraud. If you suspect potential health care fraud, please let us know.

Some of the factors that could indicate potential fraud include:

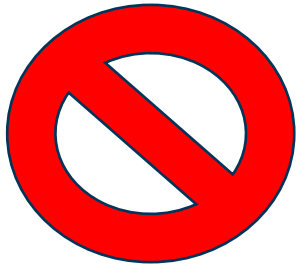
- Resubmitting denied claims (e.g., billing for the same services using a different procedure code after the first procedure was denied)
- Billing for services that aren't covered by coding the service as a procedure that is a covered service
- Altering claims or patient record (e.g., date inserted, items handwritten when the rest of claim isn't)
- Misusing or misspelling medical terms
- Listing services as rendered in another state or on a holiday or weekend
- Submitting multiple billings for the same service
- Billing for services that haven't been rendered
- Billing for an amount that doesn't correspond to the services rendered
- Altering receipts or claims
- Using the same last name for both the provider and the patient (most benefits list an exclusion of providers billing for the treatment of family members)
- Circumventing benefit exclusions (patient exhausts all physical therapy benefits and the provider continues to render physical therapy services and bills them as an office visit or submits the physical therapy services under the spouse's name)
- Submitting high dollar claims (e.g., charges for the service being billed are out of the ordinary)

Common Areas of Potential DMEPOS FWA

Patient complains of receiving duplicate DME supplies or equipment; or receiving more often than prescribed.

Patient complains of receiving EOB's or bills for supplies or equipment not received; or not prescribed (may be documented as prescribed by you or have your signature as the "prescribing provider" – but you did not prescribe.

Patient complains of being contacted by DME company and offered "free" equipment or supplies in exchange for their insurance identification number.



Ordering or Prescribing medically unnecessary services.

Billing for customizations or modifications to DME that was not provided.

DME company offers gifts and enticements for referrals

Reporting Potential Fraud, Waste, and/or Abuse

November 2023

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Reporting Fraud, Waste, and Abuse

If you suspect Fraud, Waste, or Abuse, please report it so we may look into your concerns.

You have the option to remain anonymous at all times. You do not have to give your name. We have a team of people who look into all calls or mail regarding possible Fraud, Waste, or Abuse of health care services.

Highmark Wholecare (PA)

Delivery Code: FIPR
Highmark Wholecare
Attn: FWA/SIU Unit
120 Fifth Ave.
Pittsburgh, PA 15222

844-718-6400

Online Form

SSIU@highmarkwholecare.com

Highmark Health Options (DE)

Delivery Code: HHOFRAUD
Highmark Health Options
120 Fifth Ave.
Pittsburgh, PA 15222

844-325-6256

Online Form

SIU_HHO@highmark.com

Reporting Fraud, Waste, and Abuse

Highmark – PA & DE

P.O. Box 890138
Camp Hill, PA 17089-0138

1-800-438-2478

Online Form

Fax: 717-635-4590

Highmark WV

614 Market Street
P.O. Box 1948
Parkersburg, WV 26102

800-788-5661

Online Form

Fax: 717-635-4590

Highmark NY

257 W. Genesee Street
Buffalo, NY 14202

800-333-8451 or 800-314-0025

Online Form

Fax: 717-635-4590

Resources

DMEPOS Quality Standards: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/DMEPOSQuality/DMEPOSQualBooklet-905709.html

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Order Requirements: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/dmepos-order-requirements

Standard Documentation Requirements for All Claims Submitted to DME MACs https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426#:~:text=All%20claims%20for%20items%20billed,SWO)%20(see%20below).

Noridian: https://med.noridianmedicare.com/web/jadme/dmepos

Provider specialty: Durable medical equipment (DME): https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00209704

Centers for Medicare & Medicaid Services - MCD Search Results https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=Durable%20Medical%20Equipment&keywordType=starts&areaId=s45&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) https://www.niddk.nih.gov/health-information/diabetes/overview/managing-diabetes/continuous-glucose-monitoring#who

Thank you!

- Please submit any questions to: Kylie.Wilson@HighmarkHealth.org

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