moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM072
Policy Title:	Supply Limits For Ongoing Medical Supplies		
Section:	Medicine	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☐ All dates ☒ Specific date(s): April 12, 2021 and following ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☒ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	3/10/2021	Initially Published:	4/14/2021
Last Updated:	8/9/2023	Last Reviewed:	8/9/2023

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No
Last Update Effective Date for Texas:	8/9/2023

Reimbursement Guidelines

A. Supply Limits

1. For medical supplies with ongoing regular use, Moda Health will allow pharmacies and DME suppliers to dispense, ship, and bill up to a 90-day supply of the usual medical needs of the member at a time.
2. Additional quantities billed more often than every 3 months will require documentation of increased utilization/medical necessity.
3. Examples of medical supplies with ongoing regular use:
    a. Diabetic test strips and lancets
    b. Insulin syringes
    c. Ostomy supplies
    d. Etc.

B. Exceptions

1. Any supply code with a description that specifies per month or a one month's supply. For these codes only one (1) unit of service (UOS) may be billed at a time.
2. Billing more than 1 UOS per calendar month will be denied to provider liability as exceeding the MUE or maximum quantity allowed.
3. Procedure codes to which this exception applies include:

Code	Code Description
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit
E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit
E0447	Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (LPM)
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service

Note: For K0553, See 2022-03-31-MLNC for CMS instructions for correct billing and issuing sufficient supplies of K0553 to ensure patients don't run out of supplies before the end of the month. (CMS[8])

C. Billing Requirements

1. The date of service billed is to be the date of delivery documented in the proof of delivery. (CMS[9])
2. Date ranges are not allowed. The date of delivery is to be listed in both the From Date and the To Date field on the claim.
3. The "Delivery Date/Date of Service" on the claim must not precede the date of the prescribing provider's signature on the written order. (CMS[3])

D. Documentation Requirements

1. Physician's orders and proof of delivery documentation must be kept on file by the billing provider.
2. Physician orders and/or proof of delivery documentation may be requested at times for review to validate orders, quantities, patient receipt, and correct billing and coding.
    a. Proof of delivery (POD) is a supplier standard as noted in 42 CFR § 424.57(c)(12). (CMS[7, 9]) Suppliers are required to maintain proof of delivery documentation in their files, and to provide the documentation upon request. (Noridian Medicare[4], CMS[9, 10])
    b. All orders for services and supplies must be signed.
    c. The reader or reviewer must be able to determine from the information in the documentation on which date the service or supply was performed or ordered. () The

documentation needs to contain enough information for the reviewer to determine the date on which the supply or item(s) was ordered. (Noridian Medicare[5], CMS[12])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMN	=	Certificate of Medical Necessity
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DIF	=	DME Information Form
DME	=	Durable Medical Equipment
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
LCD	=	Local Coverage Determination
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
NCD	=	National Coverage Determination
POD	=	Proof of Delivery
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill
UOS	=	Unit(s) of Service

Acronym or Abbreviation		Definition
WOPD	=	Written Order Prior to Delivery

Definition of Terms

Term	Definition
Proof of delivery	A complete record tracking the item(s) from the DMEPOS supplier to the beneficiary, containing all the elements of information required by Noridian/CMS. (Noridian[4])

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

The supply allowance (code K0553) is billed as 1 Unit of Service (UOS) per thirty (30) days. Only one (1) UOS of code K0553 may be billed to the DME MACs at a time. Billing more than 1 UOS per 30 days of code K0553 will be denied as not reasonable and necessary. (Noridian[1])

The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the "Initial Date" of the CMN or DIF or 3 months from the date of the physician's signature. (CMS[2])

For items requiring a WOPD, the contractors shall verify that the date of the written order is on or before the date of delivery… (CMS[3])

"Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery documentation must be maintained in the supplier's files for seven years (starting from the date of service). ... Proof of delivery is also one of the supplier standards as noted in 42 CFR § 424.57(c)(12). … Proof of delivery documentation must be made available, within the prescribed timeframes, … upon request. For any items that do not have proof of delivery from the supplier, such claimed items shall be denied … and overpayments recovered." (CMS[10])

"Suppliers must maintain proof of delivery documentation in their files for 7 years (starting from the date of service). Section 1833(e) grants MACs the authority to request any information necessary to determine the amounts due. This includes proof of delivery to verify that the beneficiary received the Durable Medical Equipment Prosthetic, Orthotics, & Supplies(DMEPOS) item and to determine the amounts to pay the provider for the item. Proof of delivery is a supplier standard as noted in 42 CFR Section 424.57(c)(12).

Initial Delivery:
There are three methods of delivering items of DMEPOS to beneficiaries:

- Supplier delivering directly to the beneficiary or designee
- Supplier utilizing a delivery/shipping service to deliver items
- Delivery of items to a nursing facility on behalf of the beneficiary

Upon receipt, the designee (who may not be any party with a financial interest) must legibly sign and accept the item(s). If the signature is not legible, the supplier/shipping service should note the name of the designee on the delivery slip. The beneficiary, designee, or the supplier should also enter the date of delivery. The date that the beneficiary got the DMEPOS item should be the date of service on the claim. If the supplier uses a delivery/shipping service, the supplier may use the shipping date as the date of service

on the claim. The shipping date can be the date the delivery/shipping service label is created or the date the item is retrieved for delivery." (CMS[9])

Cross References

A. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

B. "Medically Unlikely Edits (MUEs)." Moda Health Reimbursement Policy Manual, RPM056.

References & Resources

1. Noridian Healthcare Solutions, LLC. "Glucose Monitors." Noridian Healthcare Solutions, LLC. LCD 33822. Last updated: February 14, 2020. Last accessed: March 23, 2021. https://med.noridianmedicare.com/documents/2230703/7218263/Glucose+Monitors/b300483e-8205-47cf-9a04-36bad7ac2eea .

2. CMS. "Completing a CMN or DIF." Medicare Program Integrity Manual, Chapter 5 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items and Services Having Special DME Review Considerations, § 5.5.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf .

3. CMS. "Timing of the Order/Prescription." Medicare Program Integrity Manual, Chapter 5 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items and Services Having Special DME Review Considerations, § 5.2.4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf .

4. Noridian Medicare. "Proof of Delivery." Last accessed March 26, 2021. https://med.noridianmedicare.com/web/jddme/topics/documentation/proof-of-delivery .

5. Noridian Medicare. "Medical Documentation Signature Requirements." Last accessed March 26, 2021. https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements .

6. CMS. "Physician Assistant Rules Concerning Orders and CMNs." Medicare Program Integrity Manual, Chapter 5 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items and Services Having Special DME Review Considerations, §5.8. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf .

7. CMS. "Supplier Proof of Delivery Documentation Requirements." Medicare Program Integrity Manual, Chapter 4 – Program Integrity, § 4.26. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf .

8. CMS. "Continuous Glucose Monitor: Provide Supplies for a Calendar Month." *MLN Connects® Newsletter*, dated Thursday, March 31, 2022. Last accessed April 11, 2022. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2022-03-31-mlnc#_Toc99524250 .

9. CMS. "Proof of Delivery Documentation Requirements." *MLN Matters,* SE19003, January 17, 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19003.pdf.

10. CMS. "Supplier Proof of Delivery Documentation Requirements." Medicare Program Integrity Manual, Chapter 4 – Program Integrity, § 4.7.3.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf .

11. CMS. "Signature Requirements." Medicare Program Integrity Manual, Chapter 3 3 - Verifying Potential Errors and Taking Corrective Actions, § 3.3.2.4. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf .

12. CMS. "Signature Dating Requirements." Medicare Program Integrity Manual, Chapter 3 3 - Verifying Potential Errors and Taking Corrective Actions, § 3.3.2.4.H. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf .

Background Information

We intermittently receive provider inquiries, member and/or provider appeals involving the quantity of ongoing medical supplies allowed to be dispensed at one time. Providers have commented that "CMS allows a 90-day supply" to be dispensed at a time. We have searched for a CMS source to verify this comment and have been unable to locate a policy statement applying to supply items in general; we have only found NCDs or LCDs addressing time frames and quantities of specific HCPCS codes such as certain diabetic supplies.

In response, we have reviewed the best information available and developed the administrative decision guidelines documented in this policy to remove barriers to care and serve our member's needs while also limiting the potential for overpayments for supplies not used or no longer necessary.

Should specific CMS guidance be developed or change, this policy will be reevaluated.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
8/9/2023	Annual review. Section D.2.c rephrased; second footnote added. Cross References: Hyperlinks added. References & Resources: 2 entries added.
7/13/2022	Formatting & Clarification/Update: Change to new header. Coding Guidelines & Sources: 2 CMS quotes added. Cross References: 1 entry added. References & Resources: 2 CMS entries added, TX equivalents of Noridian references. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
4/14/2021	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
3/10/2021	Original Effective Date (with or without formal documentation). Policy based on research and internal administrative decision.