Medicare Face-to-Face Rules

Documentation Requirement Guidebook

Home Medical
Durable Medical Equipment
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• Every item subject to Face-to-Face requirement will also be subject to mandatory detailed written orders prior to delivery. This means NO MORE VERBAL ORDERS can be accepted on these products.

• Medicare beneficiaries discharged from a hospital do not need to receive a separate Face-to-Face evaluation. If a physician needs to order a Specified Covered Item for a beneficiary after an inpatient stay, the physician may use a Face-to-Face evaluation (done by a hospitalist or in-house physician), if the evaluation occurred within the 6 months prior to prescribing the equipment.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.

NOTE: Regarding all the Face-to-Face guidelines contained within the following pages of this booklet: These are Medicare’s current guidelines, and as such are subject to change without notice.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:

1. Physician’s Name
2. Prescriber’s NPI
3. Beneficiary name
4. Start date of order (if different from the date of the order)
5. DME item ordered
6. Signature of prescriber
7. Date of prescriber’s Signature

![Prescription Example]

Additional requirements, if applicable:
- Dosage or concentration
- Route of administration
- Frequency of use
- Duration of infusion
- Quantity to be dispensed
- Number of refills
Important Facts:

CMS expects that the patient’s medical records will reflect the need for the item ordered. The patient’s medical records include:

- Physician’s office records
- Hospital records
- Nursing home records
- Home health agency records
- Records from other healthcare professionals
- Test results

Each time a new prescription is ordered for a specified item, a new Face-to-Face exam is required. Medicare requires new prescriptions:

- If the claim is for a purchase or initial rental
- If there is a change in accessory, supply, drug, etc.
- If the LCD (local coverage determination) requires renewal
- If an item is replaced
- If the supplier is changed
- If required by state law

Other Stipulations of the Rule Include:

- A prescription is not considered a part of the medical record.

- Supplier-produced records, even if signed by the ordering Physician, and attestation letters, are not considered by Medicare as part of the medical record.
Durable Medical Equipment
Face-to-Face Rule

Other Stipulations of the Rule Include:

- Templates and forms, including CMNs, are subject to corroboration with information documented in the patient’s medical record.

- While typically PTs, OTs, and Speech Language Pathologists (SLPs) participate in the assessment and evaluation of Medicare beneficiaries, for the purpose of ordering DME items, they cannot independently document the Face-to-Face visit.

- Signature and date stamps are not allowed.

- Multiple items can be supported by a single Face-to-Face evaluation, so long as each item’s medical necessity is documented in the patient’s medical record.

Physician Compensation

- CMS has established a G-Code (G0454) to compensate Physicians who document that a PA, NP, or CNS performed the Face-to-Face evaluation.

- The G-Codes may only be used when Physician documents a Face-to-Face evaluation that is performed by a PA, NP, or CNS.

- If the physician performed the Face-to-Face evaluation him/herself, the G-Code does not apply when the Physician bills an evaluation and management code.

- If multiple orders for covered items originate from one Face-to-Face evaluation, the Physician is only eligible for the G-Code payment once.
Hospital Beds
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:

(See Face-to-Face quick reference guide)

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s Signature

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John Doe, M.D.
Any Town, USA
Phone: (555) 555-555

1. NPI: 1234767890

2. Name: William Smith
   Address: 555 My Street, Any Town

3. Date: 07/01/2013
   DOB: 12/15/1960

4. RX
   Semi-electric hospital bed with side rails & mattress

5. Signature of Prescriber: John Doe, M.D.
6. Signature Date: 07/01/2013
   Name (Printed): John Doe, M.D.
Hospital Bed
Face-to-Face Rule

HCPCS code(s) affected:

E0260: Hospital bed semi-electric (head and foot adjustment) with side rails and mattress
E0261: Hospital bed semi-electric (head and foot adjustment) with side rails without mattress
E0301 - E0304: Heavy duty hospital bed
E0255-E0256: Variable height hospital bed

Coverage Criteria:

A standard fixed height hospital bed is covered if one or more of the following criteria are met and documented in the patient’s medical record:

− The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed, OR
− The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, OR
− The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to heart failure, chronic pulmonary disease, or problems with aspiration, OR
− The patient requires traction equipment, which can only be attached to a hospital bed.

Other types of hospital beds are covered if one or more of the previous criteria are met and documented in the patient’s medical record, AND:

− Variable height - The patient requires a bed height different than a fixed height bed to permit transfers to a chair, wheelchair, or standing position.
− Semi-electric - The patient requires frequent changes in body position and/or has an immediate need for a change in body position.

− Heavy-duty extra-wide - The patient’s weight is more than 350 pounds but less than 600 pounds. Patients weighing more than 600 pounds would qualify for an extra-heavy-duty bed.

Note: Total electric hospital beds are NOT covered.

Accessories:

Certain accessories are often needed as part of the patient’s treatment plan. The need for each additional item must be addressed in the Face-to-Face evaluation and documented in the patient’s medical record. The coverage criteria for the most commonly ordered accessories are:

− Trapeze equipment - The patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

− Heavy-duty trapeze equipment - The patient meets the criteria for a regular trapeze but weighs more than 250 pounds.

− Bed cradle - The patient requires this item to prevent contact with the bed coverage.

− Side rails - The patient’s condition requires this item and they are an integral part of, or an accessory to, a covered hospital bed.
Manual Wheelchair
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:
(See Face-to-Face quick reference guide)

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s signature

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John Doe, M.D.
Any Town, USA
Phone: (555) 555-555

1. NPI# 1234767890

2. Name: William Smith
   Address: 555 My Street, Any Town

3. Date: 07/01/2013
   DOB: 12/15/1960

4. Manual wheelchair
   elevating legrests
   safety belt/pelvic strap

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Refills: __________________________
5. Signature of Prescriber: John Doe, M.D.

6. Signature Date: 07/01/2013
   Name (Printed): John Doe, M.D.
Manual Wheelchair
Face-to-Face Rule

HCPCS code(s) affected:

K0002: Standard hemi-wheelchair
K0003: Lightweight wheelchair
K0004: High-strength lightweight wheelchair
K0006: Heavy-duty wheelchair
K0007: Extra-heavy-duty wheelchair

Coverage Criteria:

A manual wheelchair for use inside the home is covered if the following criteria are met and documented in the patient’s medical record:

− The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL). A mobility limitation is one that:

  • Prevents the patient from accomplishing an MRADL entirely; OR
  • Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; OR
  • Prevents the patient from completing an MRADL within a reasonable time frame.

− The patient’s mobility limitation cannot be sufficiently resolved by the use of a cane or walker.

− The patient’s home provides adequate access between rooms, maneuvering space, and surfaces for the use of the manual wheelchair.

− Use of the manual wheelchair will significantly improve the patient’s ability to participate in MRADLs.

− The patient has not expressed an unwillingness to use the manual wheelchair.
In addition to the foregoing, one of the following criteria must be met and documented in the patient’s medical record:

- The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely propel the manual wheelchair.
- The patient has a caregiver who is available, willing and able to provide assistance with the wheelchair.

Additional Coverage Criteria for Specific Manual Wheelchairs:

In addition to the general manual wheelchair criteria noted, one of the following criteria must be met and documented in the patient’s medical record:

- Standard hemi-wheelchair - The patient requires a lower seat height because of short stature or to enable the patient to place his/her feet on the ground for propulsion.
- Lightweight wheelchair - The patient cannot self-propel a standard wheelchair in the home, but can and does propel in a lightweight wheelchair.
- High-strength lightweight wheelchair - The patient meets one of the following criteria:
  - The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair, OR
  - The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.
  - A high-strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of the need is less than three months (e.g. postoperative recovery)
- Heavy-duty wheelchair - The patient weighs more than 250 pounds or the patient has severe spasticity.
- Extra-heavy-duty wheelchair - The patient weighs more than 300 pounds.
Wheelchair Accessories
Face-to-Face Rule

HCPCS code(s) affected:

E0973, K0017, K0018, K0020: Adjustable arm height option
E2209: Arm trough
E0990, K0046, K0047, K0053, K0195: Elevating leg rests
E2201 - E2204: Non-standard seat width and/or depth
E0974: Anti-rollback device
E0978: Safety belt/pelvic strap
E1226: Manual fully reclining back

Coverage Criteria:

Options and accessories for wheelchairs are covered if the patient has a wheelchair that meets Medicare coverage criteria and documentation in the patient’s medical record substantiates the medical necessity for the item.

- **Adjustable arm height option** - The patient requires an arm height that is different than that available using non-adjustable arms and the patient spends at least 2 hours per day in the wheelchair.

- **Arm trough** - The patient has quadriplegia, hemiplegia, or uncontrolled arm movements.
Coverage Criteria (continued):

- **Elevating leg rests** - The beneficiary has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; **OR**

  The beneficiary has significant edema of the lower extremities that requires an elevating leg rest; **OR**

  The beneficiary meets the criteria for and has a reclining back on the wheelchair.

- **Non-standard seat width and/or depth** - The patient’s physical dimensions justify the need.

- **Anti-rollback device** - The patient self-propels and needs the device because of ramps.

- **Safety belt/pelvic strap** - The patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.

- **Manual fully reclining back** - The patient has one or more of the following conditions documented in the medical record:
  - At high risk for development of a pressure ulcer and is unable to perform a functional weight shift;
  - Utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.
CPAP Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.

• For CPAP, the evaluation must occur prior to the sleep study.

• When CPAP/APAP/BiPAP is ordered, order must also include heated humidifier.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:

(See Face-to-Face quick reference guide)

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s Signature

John Doe, M.D.
Any Town, USA
Phone: (555) 555-555

NPI# 1234767890

Name: William Smith
Address: 555 My Street, Any Town
Date: 07/01/2013
DOB: 12/15/1960

Rx
Provide CPAP at 12 cm/h2O, fit patient for appliance/mask, provide heated humidification

Signature of Prescriber: John Doe, M.D.
Signature Date: 07/01/2013
Name (Printed): John Doe, M.D.
CPAP Face-to-Face Rule

HCPCS code(s) affected: E0601

Coverage Criteria:

The physician must document the Face-to-Face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that is used for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details:

- **History**
  - Signs & symptoms of sleep disordered breathing, including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
  - Duration of symptoms
  - Validated sleep hygiene inventory, such as the Epworth Sleepiness Scale

- **Physical Exam**
  - Focused cardiopulmonary and upper airway system evaluation
  - Neck circumference
  - Body mass index

Specified Coverage Criteria:

An E0601 device is covered for the treatment of obstructive sleep apnea (OSA) if these criteria are met (also see next side):

- The beneficiary has a Face-to-Face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.
CPAP Face-to-Face Rule

- The beneficiary has a sleep test that meets either of the following criteria (1 or 2):
  - The Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; OR
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; OR
  - Hypertension, ischemic heart disease, or history of stroke.

- Patients who fail CPAP may be moved to a bi-level device (E0470) if an E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or a home setting.

  Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings).

  If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 does not require a new initial Face-to-Face clinical evaluation or a new sleep test.

  If an E0601 device has been used for more than 3 months and the beneficiary is switched to an E0470, a new initial Face-to-Face clinical evaluation is required, but a new sleep test is not required. A new 3 month trial would begin for use of the E0470.
Nebulizer
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.

• Face-to-Face evaluation must state why patient is unable to use hand-held inhaler.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:

(See Face-to-Face quick reference guide)

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s Signature

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**Rx**

Compressor/nebulizer for aerosolized medication delivery
Albuterol 2.5 mgm tid via small volume nebulizer

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Refills: 5

Signature Date: 07/01/2013
Name (Printed): John Doe, M.D.
Nebulizers

Face-to-Face Rule

HCPCS code(s) affected:

E0570: Nebulizer with compressor

Coverage Criteria:

Small volume nebulizer and related compressor - It is documented in the patient’s medical record that:

• It is reasonable and necessary to administer albuterol, arformoterol, budesonide, cromolyn, formoterol, ipratropium, levalbuterol, or metaproterenol for the management of obstructive pulmonary disease; OR

• It is reasonable and necessary to administer dornase alpha to a patient with cystic fibrosis; OR

• It is reasonable and necessary to administer tobramycin to a patient with cystic fibrosis or bronchiectasis; OR

• It is reasonable and necessary to administer pentamidine to a patient with HIV, pneumocytosis, or complications of organ transplants; OR

• It is reasonable and necessary to administer acetylcysteine for persistent thick or tenacious pulmonary secretions.
Oxygen Concentrators, POCs and Transfill Systems
Face-to-Face Rule

- Certain HCPCS codes for oxygen products are not included in the Face-to-Face rules implemented under the Affordable Care Act (ACA). These items can be dispensed based on a dispensing or verbal order. However, before the DME can bill for these products, a detailed written order must be received.

- The patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

- Specific to ordering oxygen since it is considered a drug, the dose and duration, i.e., nocturnal only, must be included on all orders to allow the dispensing to occur.
The dispensing order must minimally contain:

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s Signature

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John Doc, M.D.
Any Town, USA
Phone: (555) 555-555

1. NPI# 1234767890

2. Name: William Smith
3. Date: 07/01/2013
4. Address: 555 My Street, Any Town
   DOB: 12/15/1960
   Refills: 
   Signature of Prescriber: John Doc, M.D.
   Signature Date: 07/01/2013

Rx Oxygen via concentrator delivered by N/C at 21pm continuous. Patient to use transfilling device for ambulation in the home.

Name (Printed): John Doc, M.D.
Oxygen Concentrators, POCs, and Transfill Systems

Face-to-Face Rule

HCPCS code(s) affected:

E1390: Oxygen Concentrator
E1392: Portable Oxygen Concentrator, rental
K0738: Portable gaseous oxygen system, rental

Coverage Criteria:

Home oxygen is covered only when the following criteria are met and documented in the patient’s medical record:

- The treating Physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy AND

- The patient’s blood gas study meets required criteria, AND

- The qualifying blood gas study was performed by a Physician or by a qualified provider or supplier of laboratory services, AND

- The qualifying blood gas study was obtained under the following conditions:
  - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than, 2 days prior to the hospital discharge date, OR
  - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state, AND
  - Alternative treatment measures have been tried or considered and deemed clinically ineffective.
Specific Documentation Requirements:

Documentation for initial coverage requires information in the medical record showing:

- Evidence of qualifying test results done within 30 days before the initial date of service.
- Evidence of an in-person visit with a treating Physician/prescriber done within 30 days before the initial date of service.
- Consider including in the medical record the verbiage: “I have evaluated patient’s oxygen needs.”

Coverage of home oxygen therapy requires documentation in the medical record that the patient has:

- A severe underlying lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial disease, cystic fibrosis, bronchiectasis, widespread neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy; AND
- The patient is not experiencing an exacerbation of their underlying lung disease described above or other acute condition(s) impacting the patient’s oxygen saturation; AND
- For patients with concurrent PAP therapy, the qualifying oxygen saturation test is performed following optimal treatment of the OSA. Optimal treatment can be demonstrated by reduction of AHI/RDI to less than or equal to ten (10) events per hour; or if the initial AHI/RDI was less than ten (10) events per hour, there is further reduction in AHI/RDI. This test must be done over a minimum of two (2) hours.

A portable oxygen system requires documentation in the patient’s medical record that the patient is mobile within the home and the qualifying blood gas study was performed while at rest or during exercise.

“Blood Gas Study” shall refer to both Arterial Blood Gas (ABG) studies and pulse oximetry.
Gaseous & Liquid Oxygen
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.

• Specific to ordering oxygen since it is considered a drug, the dose and duration, i.e., nocturnal only, must be included on all orders to allow the dispensing to occur.
A detailed written order for the item must be received before the delivery of the item can take place minimally and must include the following information:
(See Face-to-Face quick reference guide)

1. Prescriber's NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber's Signature

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John Doe, M.D.
Any Town, USA
Phone: (555) 555-555

NPI: #1234567890

Name: William Smith
Address: 555 My Street, Any Town
DOB: 12/15/1960
Date: 07/01/2013

Rx

Provide portable oxygen via gaseous cylinders at 2 Lpm delivered via nasal cannula when ambulating

Refills:
Signature of Prescriber: John Doe, M.D.
Signature Date: 07/01/2013
Name (Printed): John Doe, M.D.
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Gaseous & Liquid Oxygen
Face-to-Face Rule

HCPCS code(s) affected:

E0424:  Stationary compressed gas oxygen system, rental
E0431:  Portable gaseous oxygen system, rental
E0433:  Portable liquid oxygen system
E0434:  Portable liquid oxygen system, rental
E0439:  Stationary liquid oxygen system, rental
E0441 - E0444:  Oxygen contents, 1 month’s supply

Coverage Criteria:

Home oxygen is covered only when the following criteria are met and documented in the patient’s medical record:

− The treating Physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, **AND**

− The patient’s blood gas study meets required criteria, **AND**

− The qualifying blood gas study was performed by a Physician or by a qualified provider or supplier of laboratory services, **AND**

− The qualifying blood gas study was obtained under the following conditions:
  
  • If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than, 2 days prior to the hospital discharge date, **OR**

  • If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state, **AND**

  • Alternative treatment measures have been tried or considered and deemed clinically ineffective.
Specific Documentation Requirements:

Documentation for initial coverage requires information in the medical record showing:

− Evidence of **qualifying test results done within 30 days** before the initial date of service.

− Evidence of an **in-person visit with a treating Physician/prescriber done within 30 days** before the initial date of service.

− Consider including in the medical record the verbiage: “I have evaluated patient’s oxygen needs.”

Coverage of home oxygen therapy requires documentation in the medical record that the patient has:

− A severe underlying lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial disease, cystic fibrosis, bronchiectasis, widespread neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy; **AND**

− The patient is not experiencing an exacerbation of their underlying lung disease described above or other acute condition(s) impacting the patient’s oxygen saturation; **AND**

− For patients with concurrent PAP therapy, the qualifying oxygen saturation test is performed following optimal treatment of the OSA. Optimal treatment can be demonstrated by reduction of AHI/RDI to less than or equal to ten (10) events per hour; or if the initial AHI/RDI was less than ten (10) events per hour, there is further reduction in AHI/RDI. This test must be done over a minimum of two (2) hours.

A portable oxygen system requires documentation in the patient’s medical record that the patient is mobile within the home and the qualifying blood gas study was performed while at rest or during exercise.

"Blood Gas Study" shall refer to both Arterial Blood Gas (ABG) studies and pulse oximetry.
TENS Units
Face-to-Face Rule

Effective July 1, 2013:

• The Patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered.

• A Physician, Physician’s Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written DME order and document the Face-to-Face evaluation in the patient’s medical records.

• The Face-to-Face evaluation must occur during the six months prior to the written order for each item.
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:

(See Face-to-Face quick reference guide)

1. Prescriber’s NPI
2. Beneficiary name
3. Date of order
4. DME item ordered
5. Signature of prescriber
6. Date of prescriber’s Signature

[Image of a prescription form with the following details filled in:

- NPI: 1234767890
- Name: William Smith
- Date: 07/01/2013
- Address: 555 My Street, Any Town
- DOB: 12/15/1960
- RX: TENS unit for trial
- Signature of Prescriber: John Doe, M.D.
- Signature Date: 07/01/2013]
TENS Units
Face-to-Face Rule

HCPCS code(s) affected:
E0720, E0730

Coverage Criteria:
The Physician ordering the TENS unit and related supplies must be the treating Physician for the disease or condition justifying the need for the TENS unit.

A TENS unit is covered for the treatment of patients with chronic, intractable pain or acute post-operative pain when one of the following criteria are met and documented in the patient’s medical record:

− **Acute Post-Operative Pain**
  - Coverage is limited to 30 days from the day of surgery. Payment will be made only as a rental.

− **Chronic Pain Other Than Lower Back Pain**
  All of the following criteria must be met and documented in the patient’s medical record:
    - The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
      - ✓ Headache
      - ✓ Visceral abdominal pain
      - ✓ Pelvic pain
      - ✓ Temporomandibular joint (TMJ) pain
    - The pain must have been present for at least three months
    - Other appropriate treatment modalities must have been tried and failed.
The patient has one of the listed diagnoses:

- Lumbosacral root lesions, not elsewhere classified
- Sacroilitis, not elsewhere classified
- Lumbosacral spondylosis without myelopathy
- Thoracic or lumbar spondylosis with myelopathy - lumbar region
- Lumbar intervertebral disc without myelopathy
- Lumbosacral intervertebral disc
- Intervertebral disc disorder myelopathy - lumbar region
- Post laminectomy syndrome - lumbar region
- Other and unspecified disc disorders, lumbar region
- Spinal stenosis, lumbar region without neurogenic claudication
- Spinal stenosis, lumbar region with neurogenic claudication
- Lumbago
- Sciatica
- Thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular syndrome or lower extremities
- Acquired spondylolisthesis
- Non-allopathetic lesions NEC (not elsewhere classified) - lumbar region
- Spondylosis, lumbosacral region
- Spondylolisthesis
- Fracture of vertebral column without mention of spiral cord injury, lumbar, closed
- Fracture of vertebral column with mention of spiral cord injury, lumbar, closed
- Sprains and strains of sacroiliac region - lumbosacral (joint) (ligament)
- Sprains and strains of sacroiliac ligament
- Sprains and strains of other and unspecified part of back, lumbar
- Injury to nerve roots and spinal plexus, lumbar root

The patient is enrolled in an approved clinical study that meets all of the requirements set forth by Medicare.
## HME HOME MEDICAL INSURANCE CONTRACT LIST

Partial list of contracted carriers, as of 10/9/2015. HME facilitates payments with hundreds of payors. This insurance list is subject to change.

### HME IS a provider for:
- Aetna (only HealthEOS networks)
- Anthem Blue Cross Blue Shield
- Arise
- Auxiant
- Coalition America Network
- Cypress Benefit Administrators
- Dean Health Plan-Prevea360 Ntwk
- EBC-Employee Benefit Consultants
- Group Health Cooperative Eau Claire
- HealthEOS – Multiplan Network
- Homelink
- HPS – Health Payment Systems
- Meritain
- MSC Care Mgmt (One Call Care Mgmt)
- Network Health
- PBA-Professional Benefit Admin.
- PHCS Savility Network
- Prairie States
- Prevea Health Network
- Prevea360 (exclusive)
- Tricare and ChampVA
- Trilogy Network
- UHC – United HealthCare
- UMR – incl. HealthEOS, Trilogy, UHC
- WEA
- WPS

### Medicare Advantage Plans
- AARP Medicare Complete
- Advantage by Managed Health Sys.
- Aetna Medicare Open Plan
- Anthem BCBS Medicare Advantage
- Health Net Medicare
- iCare Independent Care Health Plan
- UHC Dual Complete – Evercare
- United HealthCare Medicare

### Medicaid
- Anthem BCBS-Community Connect
- Care Wisconsin First
- Children’s Community Health Plan
- Forward Health
- iCare
- Lakeland Care
- MHS Managed Health Plan
- UHC Community Plan

### HME is NOT a provider for:
- Aurora Ntwks (Common Ground/UMR)
- CIGNA (unless Multiplan Network PPO)
- Care Improvement Plus
- Community Care Inc.
- GEHA
- HUMANA and any ChoiceCare plans
- Michigan Medicaid
- Security Health Plan - Northwoods
- UMR Aurora Groups

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36
Documentation in Medical Records Required by CMS

Documentation Requirements:
- ☐ Duration of patient’s condition
- ☐ Clinical course
- ☐ Prognosis
- ☐ Nature & extent of functional limitations
- ☐ Other therapeutic interventions & results

Key Items to Address:
- ☐ Why does the patient require the item?
- ☐ Do the physical examination findings support the need for the item?
- ☐ Signs and symptoms that indicate the need for the item
- ☐ Diagnoses that are responsible for these signs and symptoms
- ☐ Other diagnoses that may relate to the need for the item