

Building Blocks *for* Medicare Knowledge

Medicare

Requirements for Supply Reimbursement



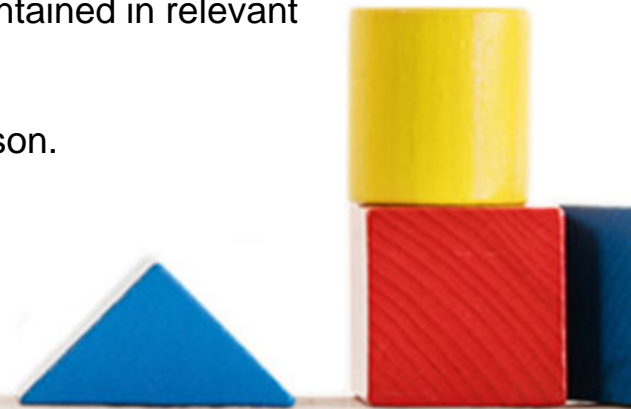
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The presentation herein was current at the time it was published. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Agenda

- DMEPOS Documentation Requirements
 - Coverage Guidelines
 - Orders
 - Amendments and Corrections to Medical Records
 - Physician/Treating Practitioner Signature Requirements
 - Amendments and Corrections to Records – Common Errors
 - Amendments
- Physician Documentation Resources



DMEPOS

Documentation Requirements

DMEPOS suppliers are your partners in caring for your patient. They 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.

- Not providing this information may result in your patients having to pay for the item themselves.
- The practitioner's cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act mandates that:

[i]n case of an item or service...ordered by a physician or a practitioner...but furnished by another entity, if the Secretary requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.



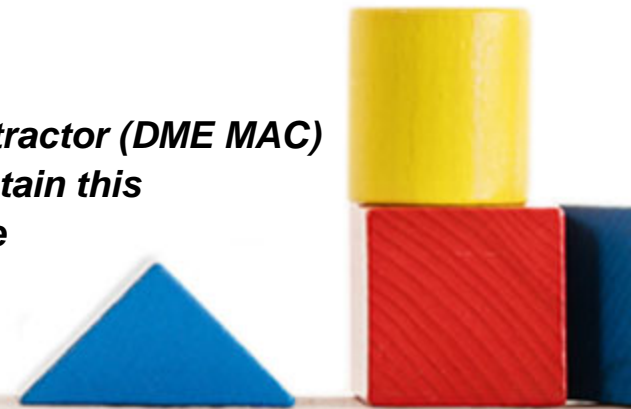


DMEPOS Documentation Requirements

Coverage Guidance

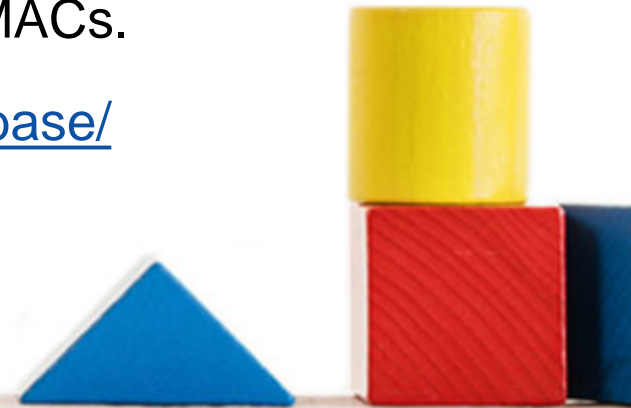
Coverage Guidance

- For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient information about the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).
- The information should include the patient's diagnosis and other pertinent information, as applicable, such as:
 - Duration of the patient's condition
 - Clinical course (worsening or improvement)
 - Prognosis, nature, and extent of functional limitation
 - Other therapeutic interventions, and results
 - Past experience with related items, etc.
- ***The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) or other auditing contractors may request that the supplier obtain this information from you in order to verify that Medicare coverage criteria has been met***



Standard Documentation Requirements for ALL Claims Submitted to DME MACs (A55426)

- DME MACs created standardized language to assist DMEPOS suppliers in understanding the information necessary to justify payment.
- The documentation requirements are compiled from Statutes, Code of Federal Regulations, Centers for Medicare and Medicaid Services (CMS) manuals, and DME MAC publications.
- This article sets out the general requirements that are applicable to all DMEPOS claims submitted to the DME MACs.
- <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=55426>



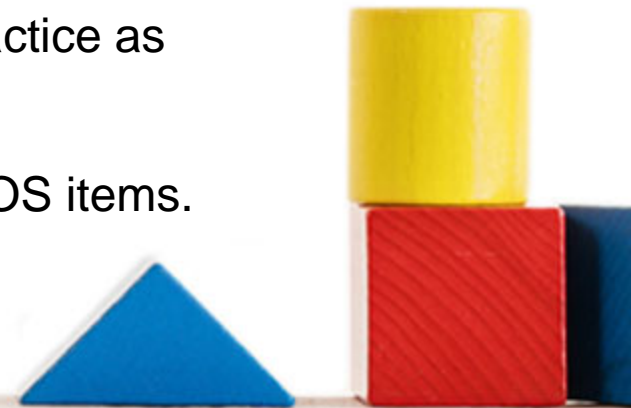


DMEPOS Documentation Requirements

Orders

Ordering Practitioners

- The term “practitioner” is used throughout this document and except where specifically noted, refers to:
 - Doctor of Medicine (MD)
 - Doctor of Osteopathy (DO)
 - Doctor of Optometry (OD)
 - Doctor of Podiatric Medicine (DPM)
 - Physician Assistants (PA)
 - Nurse Practitioner (NP)
 - Clinical Nurse Specialists (CNS)
- Prescribing of DMEPOS is limited by Medicare regulations and by the treating practitioner’s respective scope of practice as determined by the state wherein they practice.
- Chiropractors are not permitted to prescribe DMEPOS items.



Types of Orders

Orders for DMEPOS

- All claims for items billed to Medicare require a prescription (order). “All claims” refers to all claims submitted for payment of purchases and initial rentals by Medicare Part B.
- An order for each item billed must be signed by the prescribing practitioner.
 - The term “treating practitioner” is defined as the one who is directly providing care to the beneficiary for the condition(s) related to the DMEPOS ordered.
- Standard Written Orders (SWO)
 - Replaces DWO, 5EO, 7EO, DPD
 - Any item billed to Medicare **MUST** have a complete SWO prior to claim submission

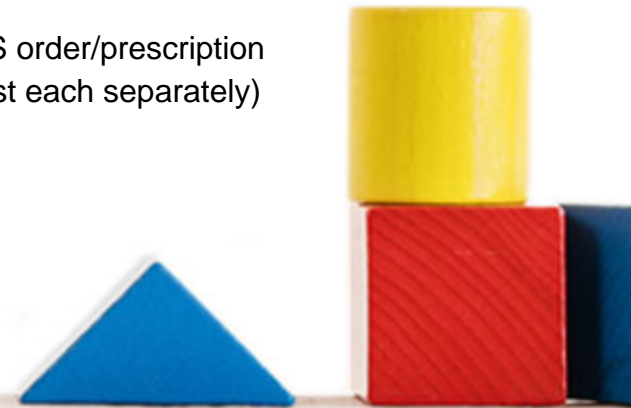
****NOTE – Verbal/Dispensing orders are no longer required***



Standard Written Order (SWO)

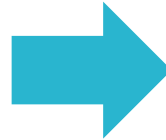
For dates of service on and after January 1, 2020, an SWO must be communicated to the supplier prior to claim submission and must contain all of the following:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
 - The description can be either general description (e.g. CPAP mask), a HCPCS code, a HCPCS code narrative, or a brand name/model number
 - For equipment – In addition to the description of the base item, the SWO may include all concurrently ordered options, as 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 DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (List each separately)
- Quantity to be dispensed, if applicable
- Treating practitioner's name or NPI
- Treating practitioner's signature



SWO: Quantity and Frequency

Quantity to be dispensed



Total # of units per refill
“Per month” or “30 days”

Quantity to be dispensed is only required for items provided on a periodic basis. Base items do not require quantity unless ordering more than one.

Example: Ostomy, Surgical Dressings, Albuterol, Oral Anti Cancer Drugs, Diabetic Supplies, etc.

Frequency of use



Daily usage
“every 4 hours” or “4 per day”

Frequency of use is not required on the Standard Written Order. However, if audited, the medical records must support the frequency provided and billed.



SWO Quantity

- Accessories/Supplies
 - Quantity is required
 - Example – 120 per month, 2 boxes, etc.

- Drugs
 - Quantity is required
 - Must indicate amount prescribed
 - Example – 31 units/month or 465 mg/month
 - » “PRN” or “OR as needed” are not acceptable
 - » Example - 31 units/month **and** as needed acceptable (payment based on 31 units/month)



Example of Standard Written Order Required Elements

ABC123 Supplier
Sunshine Street
Sunshine City, USA 17171

Date 1/14/20

Patient Name: Jane Doe Patient MBI: 1EG4-TE5-MK72

Item	Name	Current Direction s	Quant	FGY	Refills
	Albuterol				
	Test Strips 50 per/box		2		

Comments:

NOT VALID WITHOUT PRESCRIBERS SIGNATURE
Practitioners Name (PRINT) John Doe Date 01/14/20
John Doe

Date 1/14/20

Patient Name: Jane Doe Patient MBI: 1EG4-TE5-MK72

Name	Current Direction s	Quant
Glucose Monitor		
Test Strips 50 per/box		2

Name	Current Direction s	Quant	FGY
Albuterol		465mg	

ATURE
Date 01/14/20

NOT VALID WITHOUT PRESCRIBERS SIGNATURE
Practitioners Name (PRINT) John Doe 1/14/20

RX Authorized by (signature) John Doe

Prescriber Phone: 615-782-4610 #License: DEA: NPI: 1111111111

NOT VALID WITHOUT PRESCRIBERS SIGNATURE
Practitioners Name (PRINT) John Doe 01/14/20

RX Authorized by (signature) John Doe

Prescriber Phone: 615-782-4610 #License: DEA: NPI: 1111111111

Requirement of New Orders

- New order is required when:
 - 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 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.





DMEPOS Documentation Requirements

Initial Need
Continued Need
Continued Use

Initial Need Documentation

- Initial justification for medical need is established at the time items are first ordered.
- Medical records demonstrating that the items are reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription.



Continued Need Documentation

- In addition to initial justification documentation, for ongoing supplies, there must be information in the medical record to support items continue to remain reasonable and necessary.
- Information used to justify continued medical need must be timely for the date of service under review.



Continued Need Documentation

- Any of the following may serve as documentation justifying continued medical need:
 - A recent order by the treating practitioner for refills
 - A recent change in prescription
 - Timely documentation in the medical record showing usage of items
- Timely documentation is a record in the preceding 12 months unless otherwise specified in the applicable policy.



Continued Use Documentation

- Describes ongoing utilization of supplies or rental items by beneficiary.
- Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies.
 - No monitoring of purchased items or capped rental items converted to purchase is required.
- Discontinue billing when rental items and ongoing supplies are no longer being used.
- Beneficiary medical records or supplier records may be used to confirm items continue to be used.
- 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 an ordering practitioner determines that the replacement device, or replacement part of such a device, is reasonable and necessary.



Continued Use Documentation

- Any of the following may serve as continued use documentation:
 - Timely documentation in the beneficiary's medical record showing usage of the item, related options/accessories and supplies
 - Supplier records documenting the request for refill/replacement of supplies in compliance with the refill request documentation requirements
 - Supplier records documenting confirmation of continued use of a rental item
- Timely documentation is a record in the preceding 12 months unless otherwise specified in the applicable policy.





DMEPOS Documentation Requirements

**Amendments and Corrections
to Medical Records**

Medical Records Format – SE1022

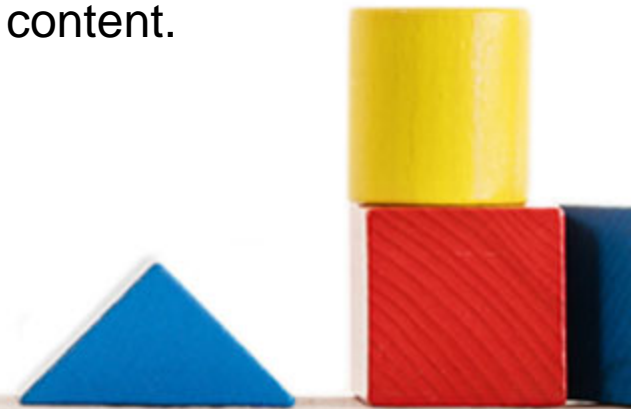
- The Medicare program does not have requirements for the media formats for medical records.
- However, the medical record needs to be in its original form or in a legally-reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities.

Medical Records Retention & Media Formats for Medical Records-MLN Matters
SE1022: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1022.pdf>



Amendments and Corrections to Medical Records

- In all cases, regardless of whether the documentation is maintained or submitted in paper or electronic form, any medical records that contain **amendments**, **corrections**, or **addenda** must:
 - Clearly and permanently identify any amendment, correction or delayed entry as such; and
 - Clearly indicate the date and author of any amendment, correction, or delayed entry; and
 - Not delete, but instead, clearly identify all original content.



Amendments to Electronic Records

- Records sourced from electronic systems containing amendments, corrections or delayed entries must:
 - Distinctly identify any amendment, correction or delayed entry; and,
 - Provide a reliable means to clearly identify the original content, the modifier content, and the date and authorship of each modification of the record.
- Provided both the original record and any amendments that were made to the original note.
- Failure to provide a complete medical note or a record with changes inconsistent with the CMS manual instructions may result in claim denial.



Corrections to Paper Records

- Use a single line strike through the content, so that the original content is still readable.
- The author of the alteration must sign (or initial) and date the revision.
- Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.





DMEPOS Documentation Requirements

Physician and Treating Practitioner Signatures

Signature Requirements

The CMS Internet Only Manual outlines signature requirements for Medicare purposes.

For medical review purposes, Medicare requires that services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies. For example, if the physician's authenticated documentation corroborates the nurse's unsigned note, and the physician was the responsible party per Medicare's payment policy, medical reviewers would consider signature requirements to have been met. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable.

CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.4:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03pdf.pdf>



Handwritten Signatures

- Illegible signature – may use a signature log or attestation statement
- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.



Electronic Signatures

- Electronic signature protocols must be available and provided upon request for electronic signatures.
- Some examples of acceptable notations of electronic signatures (not all inclusive list):
 - Electronically signed by
 - Authenticated by
 - Approved by
 - Completed by
 - Finalized by
 - Signed by
 - Validated by
 - Sealed by



Treating Practitioner's Signature

Medicare requires a legible identifier for services provided/ordered

- Handwritten or electronic signature
- If a signature is missing from an order, the order is invalid.
- Stamped signatures and signature dates are not acceptable.
- Signature log will be requested if signature illegible
 - Printed name, initials and/or signature, credentials

PRINTED NAME	SIGNATURE/INITIALS	CREDENTIALS
Dr. John Smith	<i>Dr. John Smith/JS M.D.</i>	<i>M.D.</i>

- Complying With Medicare Signature Requirements:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03pdf.pdf>

Sample Attestation Statement

NOTE: This form provides a suggested format for a signature attestation statement. Submission of a signature attestation statement and use of this form is optional.

Name of Patient:	
Medicare Number:	

I, Print full name of the physician/practitioner., hereby attest that the medical record entry for Date of service. accurately reflects signatures/ notations that I made in my capacity as a(n) Insert credentials, e.g. M.D. when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Signature of Author of the Medical Record

Date

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry. Reviewers will not consider attestation statements where there is no associated medical record entry or someone other than the author (even a partner in the same group practice) of the medical record entry in question signs this statement.

- Attestation statements may be submitted to authenticate an illegible or missing signature on medical documentation
- Reviewers will consider all attestations that meet CMS requirements regardless of the date the attestation was created, except in cases where the regulations or policy indicate a signature must be in place prior to a given event or given date.



DMEPOS Documentation Requirements

**Amendments and Corrections to Medical
Records Common Errors**

Common Errors Pertaining to Medical Record Documentation

- No medical record documentation was received.
- The medical record documentation is dated after the date of service.
- The medical record documentation is illegible.
- The treating practitioner's order, Certificate of Medical Necessity (CMN), supplier-prepared statement or a treating practitioner's attestation, by itself, **does not** provide sufficient documentation of medical necessity.
- The medical record documentation is not authenticated (handwritten or electronic signature) by the author.



Amendments and Corrections

- The order contains corrections/changes that do not comply with accepted record keeping principles.

DIAGNOSIS			Prognosis
ICD-10 Code	Description		
G47.33	Obstructive sleep apnea (adult) (pediatric)		
EQUIPMENT/SERVICES			
Qty	Proc. Code	Item Name/Narrative	
1	E0601	37207 Auto CPAP Airsense 10 ResMed	
1	E0562	37207 Heated Humidifier Airsense 10	
1	A7037	6ft Tubing Slim Line (1Q3M)	
6	A7038	S9 /AS 10 Resmed Disposable Filters (2Q1M)	
1	A7035	PAP Headgear (1Q5M)	
<div style="border: 1px solid orange; border-radius: 15px; padding: 5px; display: inline-block;"> <p>1 A7033 Nasal Mask Pillow System (1Q3M)</p> </div>			

The correction to the order is missing initials and date

Example of Invalid Addition to Medical Record

12/17/15
S: [redacted] comes in with several issues this including problems associated with earache, especially on the right. She has some nausea and vomiting. She is still bereaving the death of her son who died back here within the past month from hanging around a bonfire. At an [redacted] has no [redacted] medicine [redacted] a little [redacted] O: H [redacted] Heart [redacted] posit: [redacted] A: [redacted]

idence of some osteoarthritis.

S. Hx of Asthmatic Bronchitis

[redacted]

pheral edema, but we finally got [redacted] us for a while.

IM: Toradol 30 mg, Celestone 7 mg, and B12 2 cc's.
RX: Ultram 50 mg qid.
RX: Bactrim DS bid.
SAMPLES: Kristalose and Movantik versus Linzess
[redacted], M.D.

Additions to medical records need to be initialed and dated

Valid Electronic Signature Example

Electronically signed by: [REDACTED] DO 12/07/2016 08:33 AM
Document generated by: [REDACTED] 12/07/2016 08:33 AM



Invalid Electronic Signature

Invalid Electronic Signature. Accepted by is not a valid indication of electronic signature. No Attestation Statement was submitted.

Take 3 mL (1.25 mg total) by nebulization every 8 (eight) hours as needed for wheezing or shortness of breath. - Nebulization

Orders Placed This Encounter

DME NEBULIZER [DME3 CPT(R)]

Results are available for this encounter

Level of Service

PR OFFICE/OUTPT VISIT,EST,LEVEL IV [99214]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet
Vital Signs Flowsheet

Chart Cosign

Accepted By _____, MD

99214 PR OFFICE/OUTPT VISIT,EST,LEVEL IV 6/4/2015 _____, PA 25 1

Unsigned Medical Record

Per Dr [REDACTED] patient to self cath 5 times a day for urinary retention for an indefinite period of time. Patient requires a coude catheter due to difficulty passing a straight catheter. [REDACTED] LVN

Electronically Signed by: null 10/31/2016 01:11:02 PM CDT



- If the signature is missing from medical documentation (other than an order), a signature attestation from the author of the medical record entry is acceptable

Electronically Signed by: null 10/31/2016 01:11:02 PM CDT



DMEPOS Documentation Requirements

Practitioner Documentation Resources

Practitioner Documentation Resources

Physician's Corner

- The Physician's Corner is specifically designed for the benefit of physicians and practitioners who prescribe DMEPOS items for Medicare beneficiaries.
- Included in this section is important practitioner-based information pertinent to both the practitioner and the supplier that provides the items and services to your patient.
 - JB: https://www.cgsmedicare.com/jb/mr/phys_corner.html



Practitioner Documentation Resources

Local Coverage Determinations (LCDs) and Policy Articles

These documents review the DME MAC coverage requirements including medical necessity, documentation, and additional information for the DMEPOS items ordered.

- JB: <https://www.cgsmedicare.com/jb/coverage/lcdinfo.html>



Practitioner Documentation Resources

Dear Physician Letters

- The Dear Physician letters were created by the DME MAC Medical Directors to provide detailed information and resources for practitioners to assist the DMEPOS suppliers with obtaining required documentation.
- JB: https://www.cgsmedicare.com/jb/mr/doc_req.html



Practitioner Documentation Resources

Physicians! Are you ordering... articles

- A series of joint educational articles between the DME and A/B MACs to assist the practitioner with documentation requirements needed for specific DMEPOS items.
- JB: https://www.cgsmedicare.com/jb/mr/ordering_articles.html



Practitioner Documentation Resources

Provider Enrollment, Chain, and Ownership System (PECOS)

- For any DMEPOS item to qualify for coverage by Medicare it must be ordered by a physician or treating practitioner who is eligible to order DMEPOS items and must be enrolled in PECOS.
 - Medicare Provider Enrollment
 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/Med-Prov-Enroll-MLN9658742.html>
 - PECOS Dear Physician letters
 - JB: https://www.cgsmedicare.com/jb/forms/pdf/dear_physician_pecos.pdf





Questions



Thank you for attending!