Building Blocks *for* Medicare Knowledge

Medicare

Requirements for DME Reimbursement

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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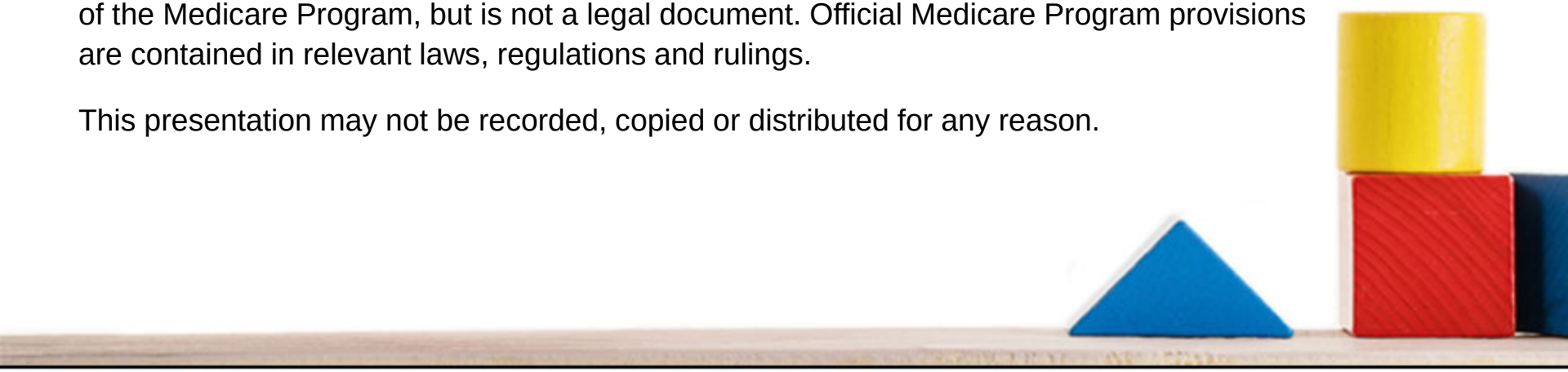
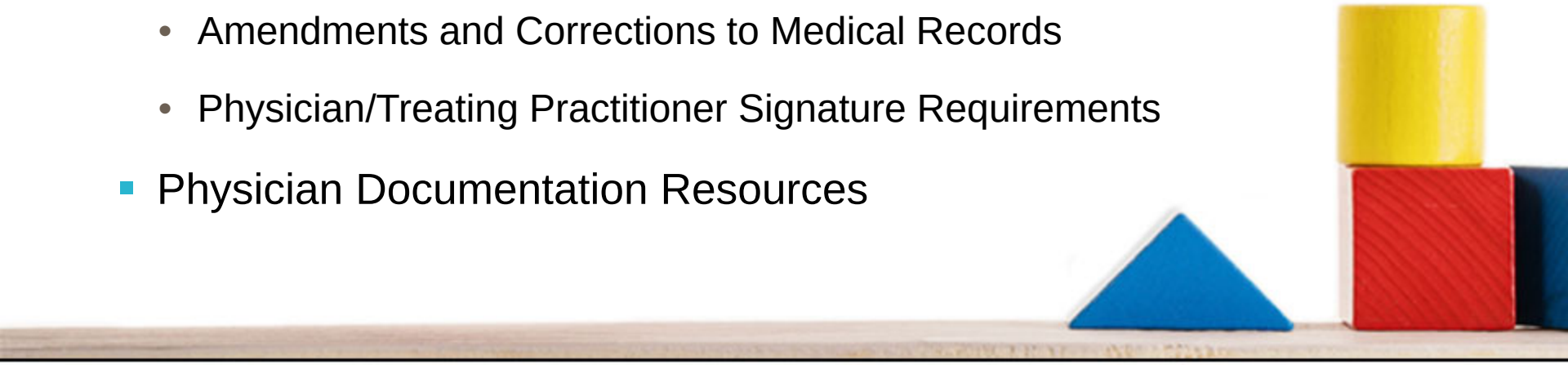


Agenda

- DMEPOS Documentation Requirements
  - Coverage Guidelines
  - Standard Written Order Requirements
  - Initial Need, Continued Need, Continued Use
  - Certificate of Medical Necessity (CMNs)
  - Condition of Payment Prior Authorization Program
  - Amendments and Corrections to Medical Records
  - Physician/Treating Practitioner Signature Requirements
- 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:

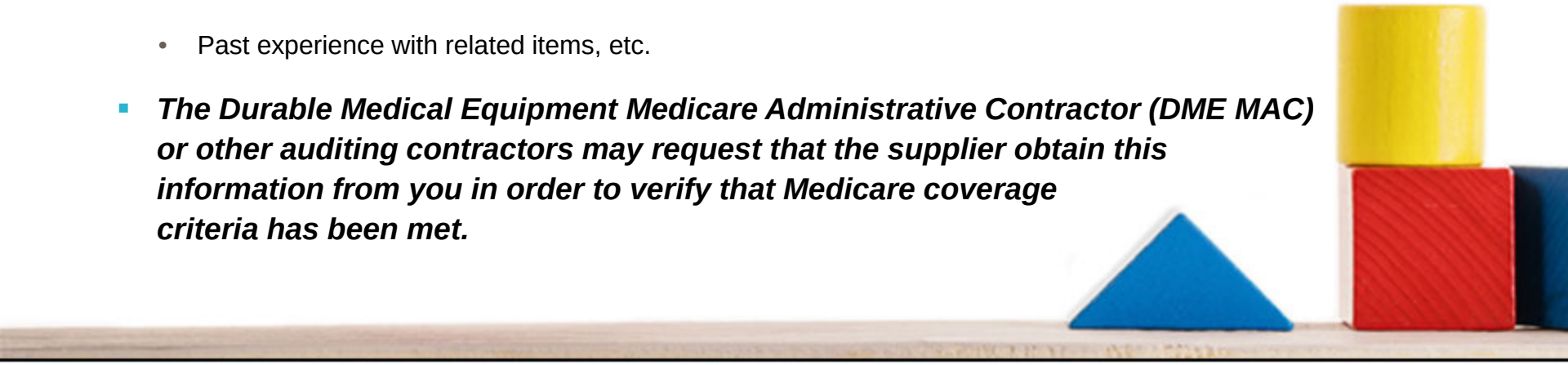
> [i]n case of an item or service...ordered by a physician or a practitioner...but furnished by another entity, if the Secretary requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner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

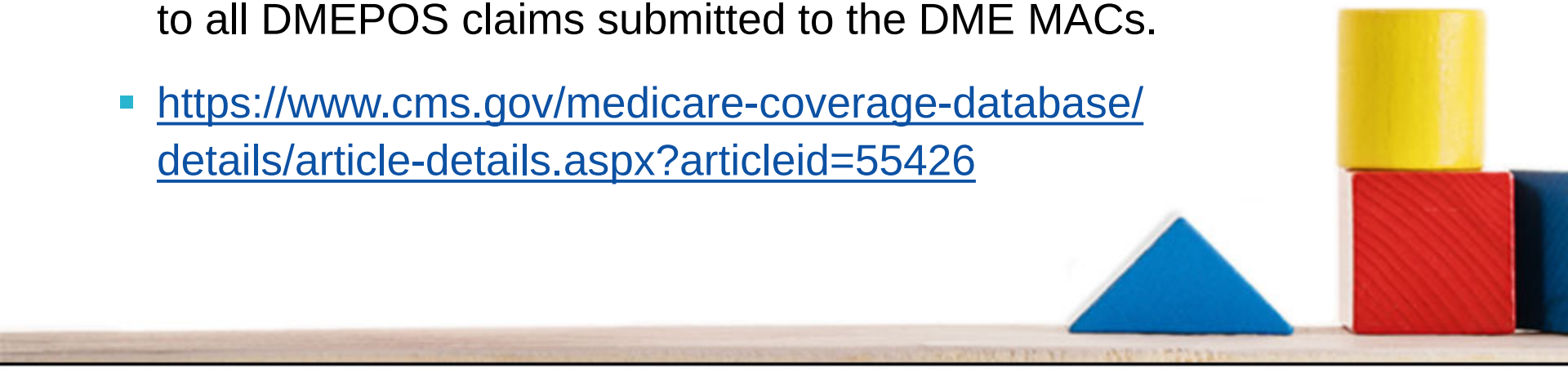
Coverage Guidance

- 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



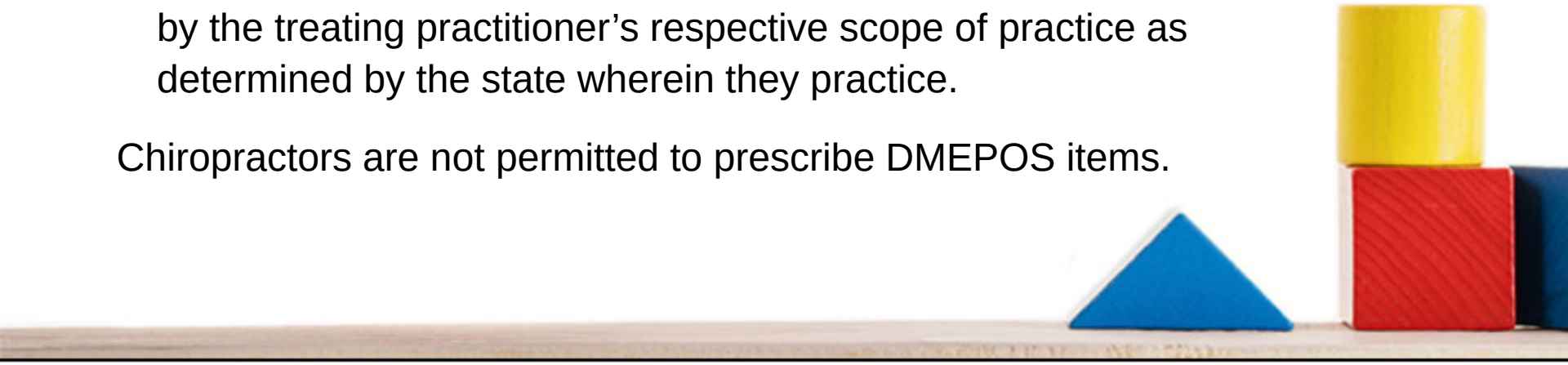
DMEPOS Documentation Requirements

Orders

Ordering Practitioners

- The term “practitioner” is used throughout this document and except where specifically noted, refers to:
  - Doctor of Medicine (MD)
  - Doctor of Optometry (OD)
  - Physician Assistants (PA)
  - Clinical Nurse Specialists (CNS)
  - Doctor of Osteopathy (DO)
  - Doctor of Podiatric Medicine (DPM)
  - Nurse Practitioner (NP)
- 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.

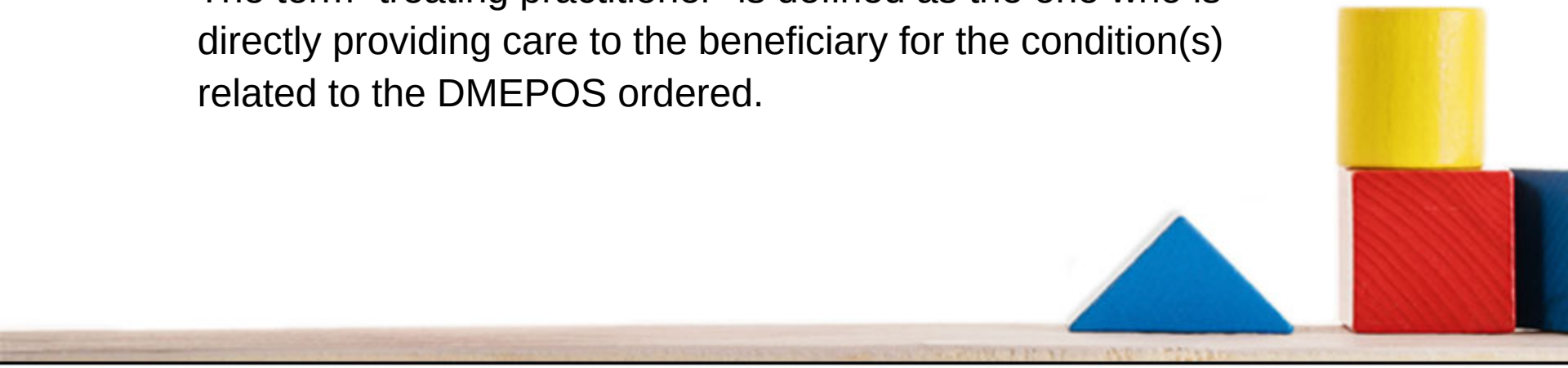
Chiropractors are not permitted to prescribe DMEPOS items.



Orders

Orders for DMEPOS

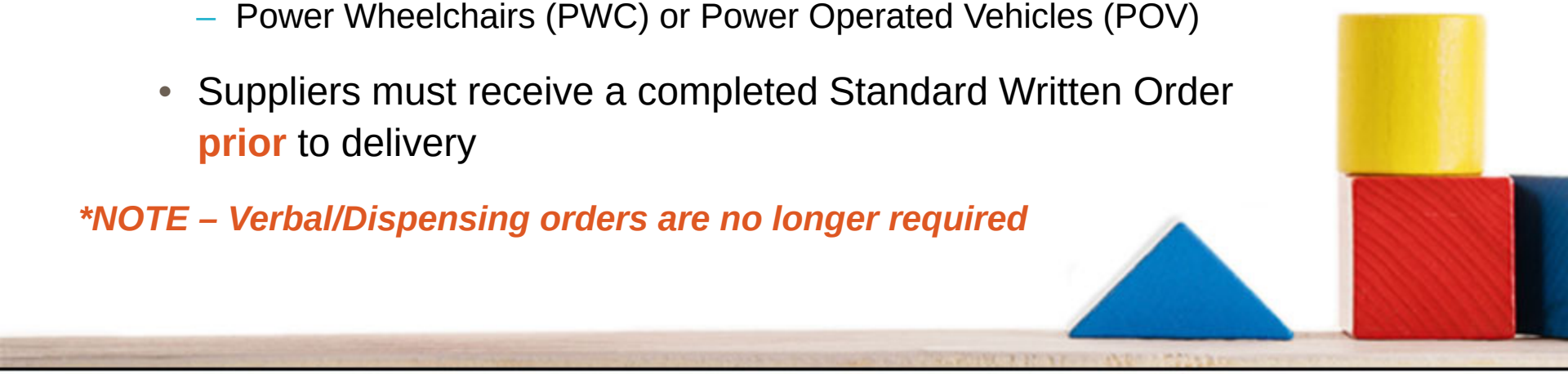
- All claims for items billed to Medicare require a prescription (order). “All claims” refers to all claims submitted for payment of purchases and initial rentals by Medicare Part B.
- An order for each item billed must be signed by the prescribing practitioner.
  - The term “treating practitioner” is defined as the one who is directly providing care to the beneficiary for the condition(s) related to the DMEPOS ordered.



Types of Orders

- **Standard Written Orders (SWO)**
  - Replaces DWO, 5EO, 7EO, DPD
  - Any item billed to Medicare **MUST** have a complete SWO prior to claim submission
- **Written Orders Prior to Delivery (WOPD)**
  - Power Mobility Devices
    - Power Wheelchairs (PWC) or Power Operated Vehicles (POV)
  - Suppliers must receive a completed Standard Written Order **prior** to delivery

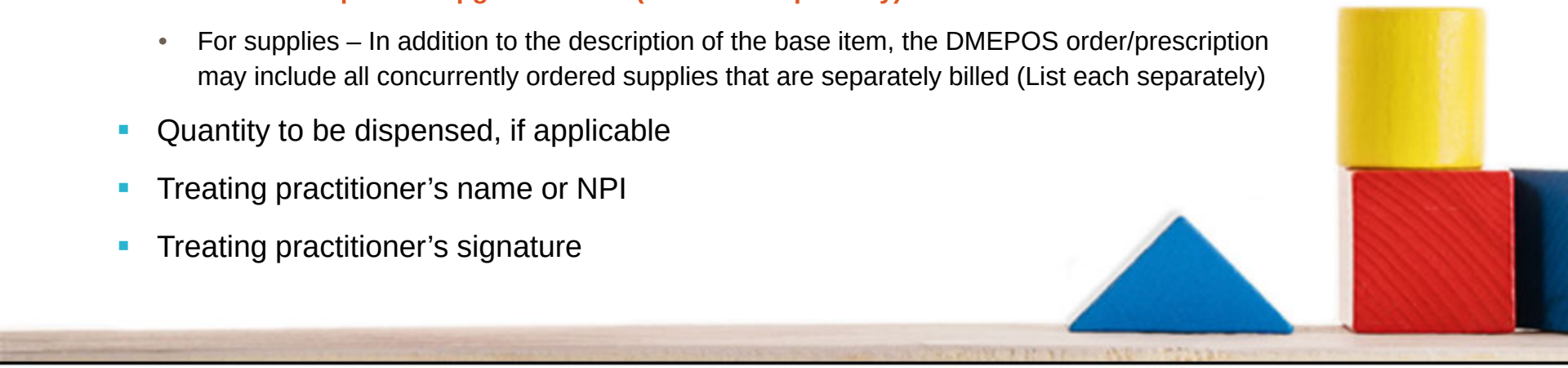
NOTE – Verbal/Dispensing orders are no longer required



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:

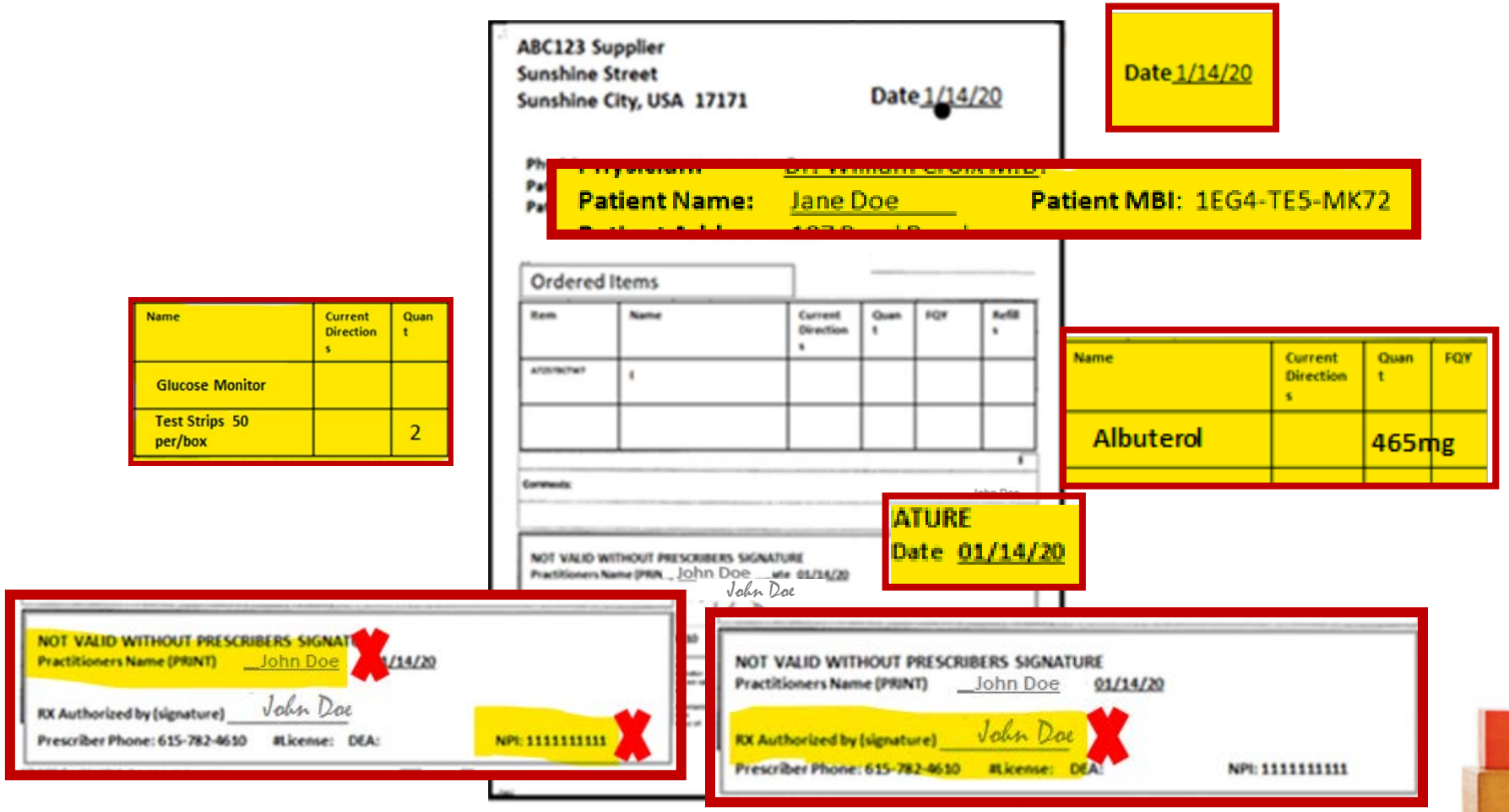
- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
  - The description can be either general description (e.g. CPAP mask), a HCPCS code, a HCPCS code narrative, or a brand name/model number
  - **For equipment – In addition to the description 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



DWO vs. SWO

DETAILED WRITTEN ORDER {dates of service prior 1/1/20}	STANDARD WRITTEN ORDER {dates of service 1/1/20 and after}
Beneficiary's name	Beneficiary's name ***OR*** MBI
Date of the order (one or two dates depending on who created DWO)	Order date
A description of all items, options, accessories or additional features that are separately billed or require an upgraded code. One of the following: ▪ General description (e.g., "wheelchair" or "hospital bed"), or ▪ HCPCS code, or ▪ HCPCS code narrative, or ▪ Brand name/model number	• The description can be either a general description (e.g., wheelchair or hospital bed), 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, 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)
Frequency of use and the quantity dispensed	Quantity to be dispensed (*if applicable*)
Treating practitioner's signature	Treating practitioner's name ***OR*** NPI
Treating practitioner's signature date	Treating practitioner's signature

Example of Standard Written Order Required Elements



Written Order Prior to Delivery and Face-to-Face Evaluation

- CMS Final Rule 1713 created Master List of codes ***potentially*** subject to:
  - Written Order Prior to Delivery (WOPD) and Face-To-Face Evaluation and/or Prior Authorization
- **Required List** is a subset of codes from the Master List and will always include PMDs since WOPD and Face-To-Face are mandated in statute (1834(a)(1)(E)(iv)).
- CMS will publish the **Required List** in *Federal Register* sometime in the near future.
  - Required List items will be subject to Written Order Prior to Delivery (WOPD) and Face-To-Face Evaluation
  - Required List will be posted on CMS and DME MAC sites
- Until Required List is published and final in the *Federal Register*, **only PMDs are subject to WOPD and Face-To-Face evaluation.**

Master List: Possible WOPD/F2F and/or Prior Authorization

- At this time, you can review the items (HCPCS) that appear in the Master List:
  - https://www.cms.gov/files/document/esrd-qip-final-rule-2019-24063.pdf-0
- This only means that the items within this list could ***potentially*** appear on the forthcoming Registered List for WOPD and Face-to-Face evaluations and/or Prior Authorizations.

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

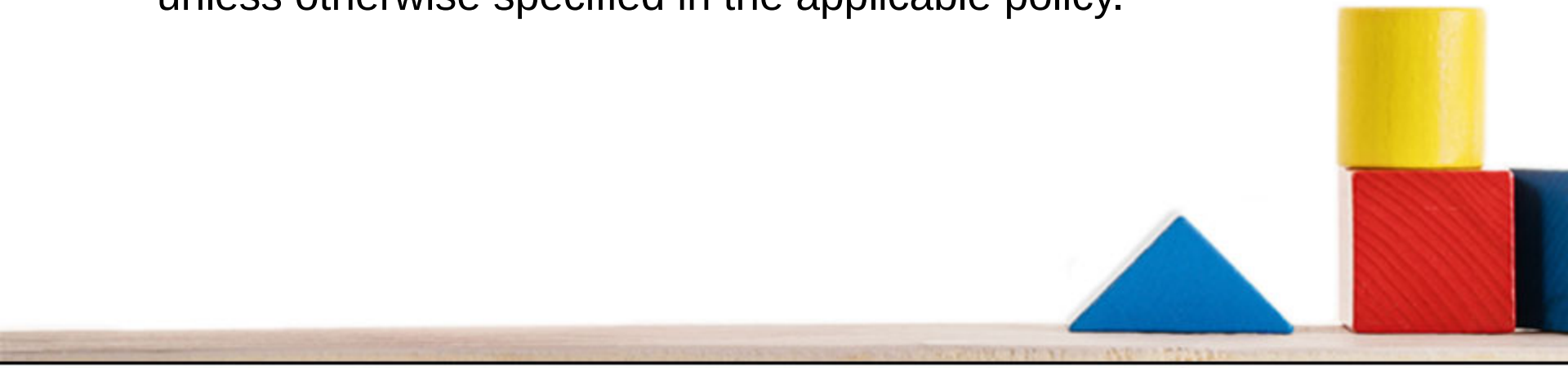
- Initial justification for medical need is established at the time items are first ordered.
- Medical records demonstrating that the items are reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription.

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

Certificates of Medical Necessity (CMNs)

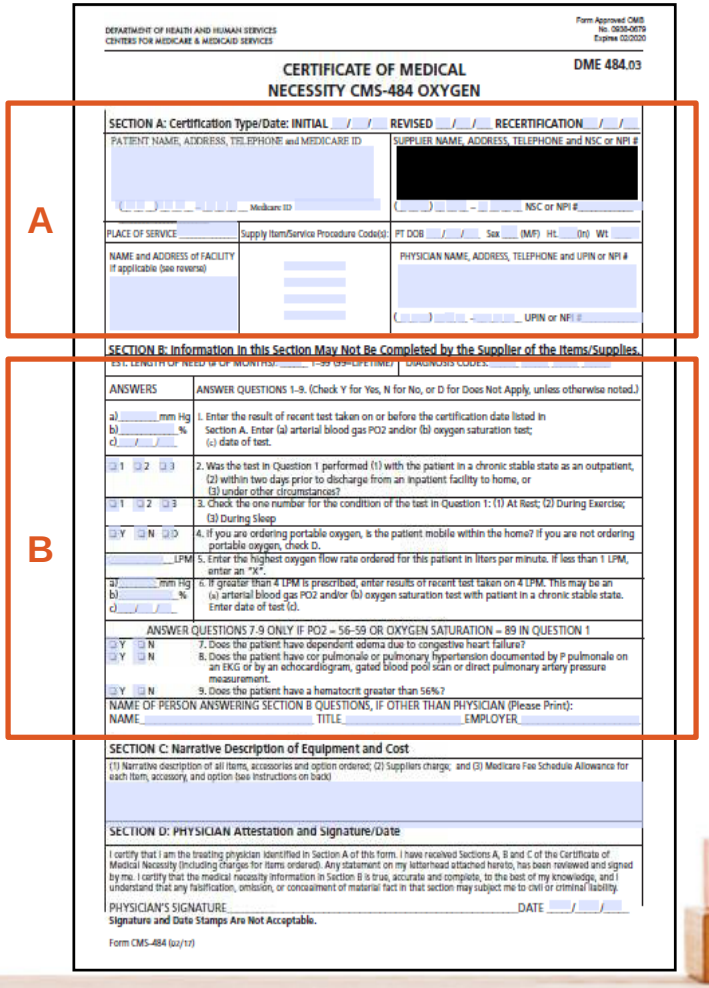
Certificates of Medical Necessity (CMNs)

A CMN, which as been completed, signed and dated by the treating practitioner, must be kept on file by the supplier that provides the medical equipment and made available upon request

- CMNs are required for:
  - Oxygen
  - Pneumatic Compression Devices
  - Osteogenesis stimulators
  - TENS (purchase only)
  - Seat lift mechanisms
- May serve as the Standard Written Order (SWO) if it contains the same information as required in a SWO
- If no original, faxed or photocopied in records before the claim is filed, the claim will be denied

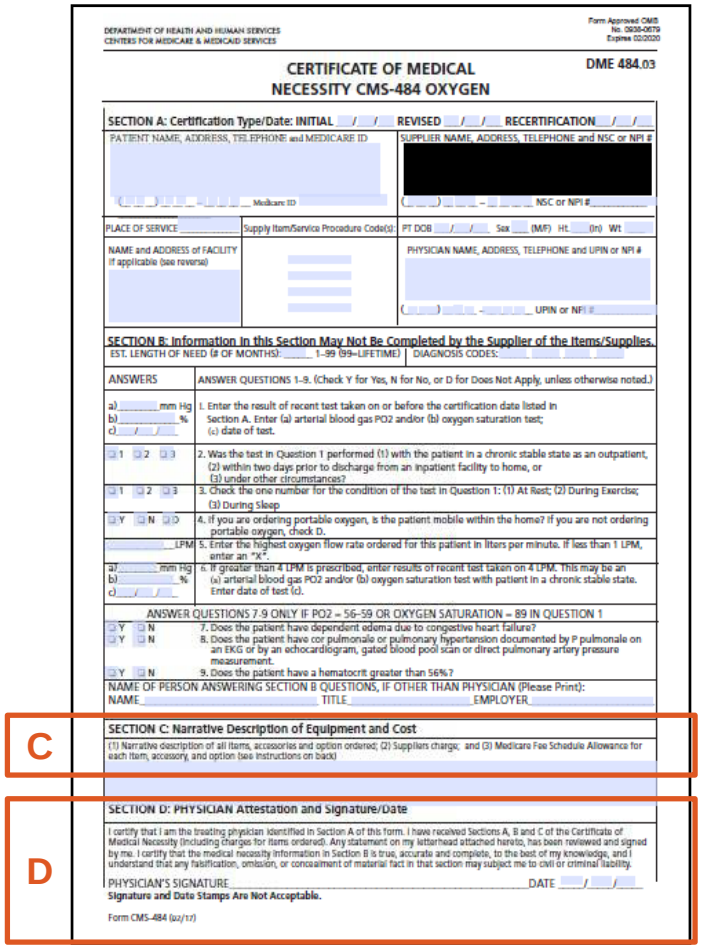
CMN Reminders

- **Section A: (Supplier)**
  - Initial date is date ordered or date delivered, establishes date of medical need
  - Revision dates do not affect recertification dates
  - Place of service is where equipment is being used
- **Section B: (Physician)**
  - Include name, title and employer if someone other than the prescribing practitioner completes
  - Indicate “D” if question does not apply to the condition of the beneficiary
  - Report diagnosis codes



CMN Reminders

- **Section C: (Supplier)**
  - Include narrative description of all items provided
  - Report supplier's charge and Medicare fee schedule allowance for each item
  - Complete before submitting to prescribing practitioner
- **Section D: (Physician)**
  - Physician, CNS, NP, or PA can sign
  - Signature stamps are no longer acceptable effective 02/02/09



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB No. 0938-0679 Expires 02/2020

DME 484.03

CERTIFICATE OF MEDICAL NECESSITY CMS-484 OXYGEN

SECTION A: Certification Type/Date: INITIAL / / REVISED / / RECERTIFICATION / /

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #

PLACE OF SERVICE | Supply Item/Service Procedure Code(s): | PT DOB / / Sex (M/F) Ht (in) Wt

NAME and ADDRESS of FACILITY If applicable (see reverse)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.
EST. LENGTH OF NEED (# OF MONTHS): 1–99 (99=LIFETIME) | DIAGNOSIS CODES:

ANSWERS	ANSWER QUESTIONS 1–9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a) mm Hg b) % c) / /	1. Enter the result of recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
1 2 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
1 2 3	3. Check the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, check D.
LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".
a) mm Hg b) % c) / /	6. If greater than 4 LPM is prescribed, enter results of recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1	
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement.
Y N	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME TITLE EMPLOYER

C

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)

D

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE DATE / /

Signature and Date Stamps Are Not Acceptable.

Form CMS-484 (12/17)

DMEPOS Documentation Requirements

Condition of Payment
Prior Authorization (PA) Program

Condition of Payment Prior Authorization

The Prior Authorization process will ensure that Medicare coverage and documentation requirements are met before the item/device/service is rendered and a claim is submitted.

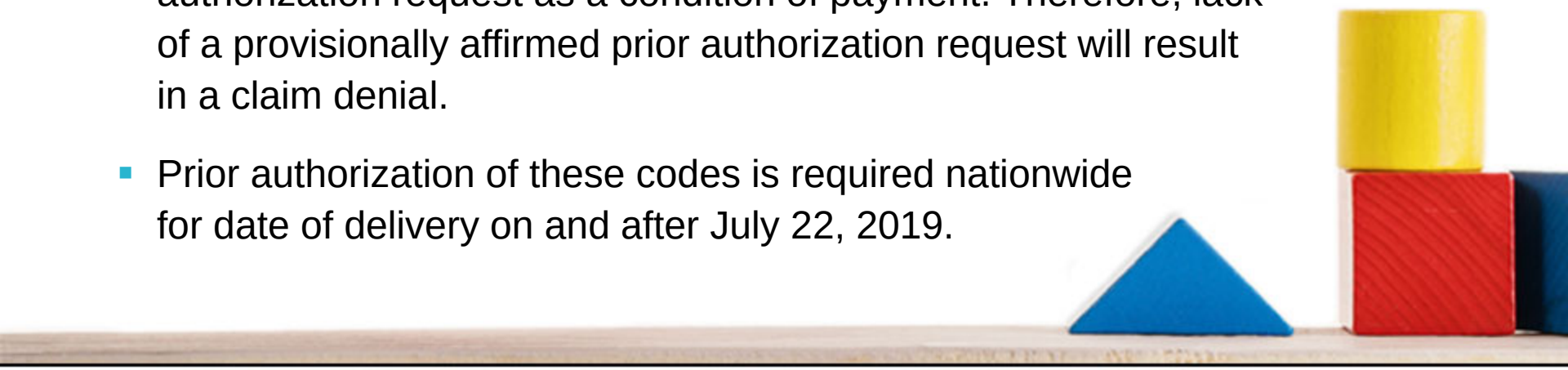
- Goal of Prior Authorization
  - Reduce unnecessary usage and billing for select items/devices/services
- Medicare will consider payment
  - Only if the beneficiary's medical record contains sufficient documentation
  - All required documentation elements outlined in Medicare policies are present and met

Prior authorization enhances the coordination and collaboration of care between the treating practitioner and the supplier to deliver the most appropriate DMEPOS item to meet the needs of the beneficiary.

Condition of Payment Prior Authorization

Power Mobility Devices

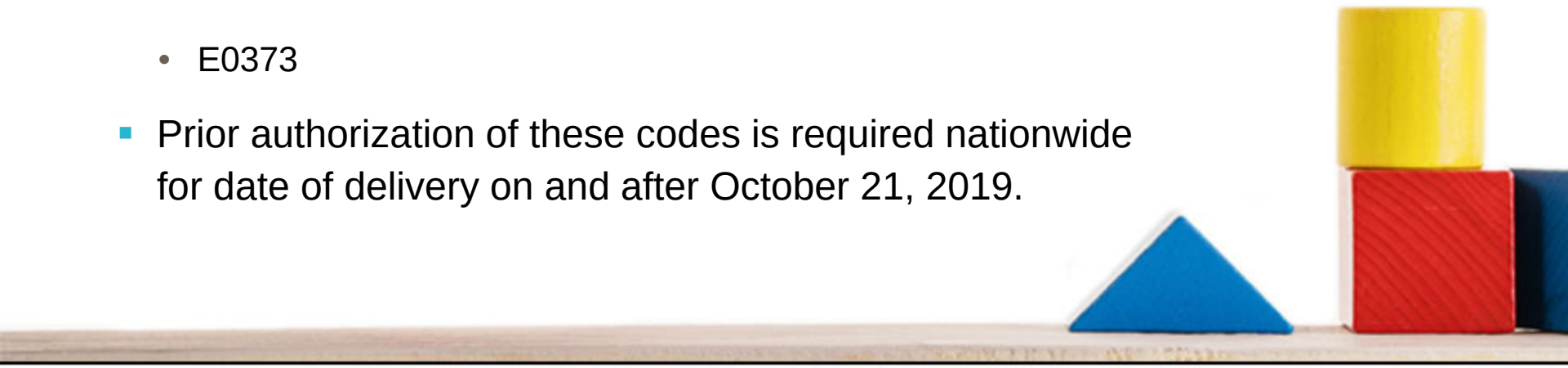
- PMDs that currently require prior authorization before delivery:
  - K0813-K0829
  - K0835-K0843
  - K0848-K0864
- All claims for affected PMDs must be associated with a prior authorization request as a condition of payment. Therefore, lack of a provisionally affirmed prior authorization request will result in a claim denial.
- Prior authorization of these codes is required nationwide for date of delivery on and after July 22, 2019.



Condition of Payment Prior Authorization

Group 2 – Pressure Reducing Support Surfaces

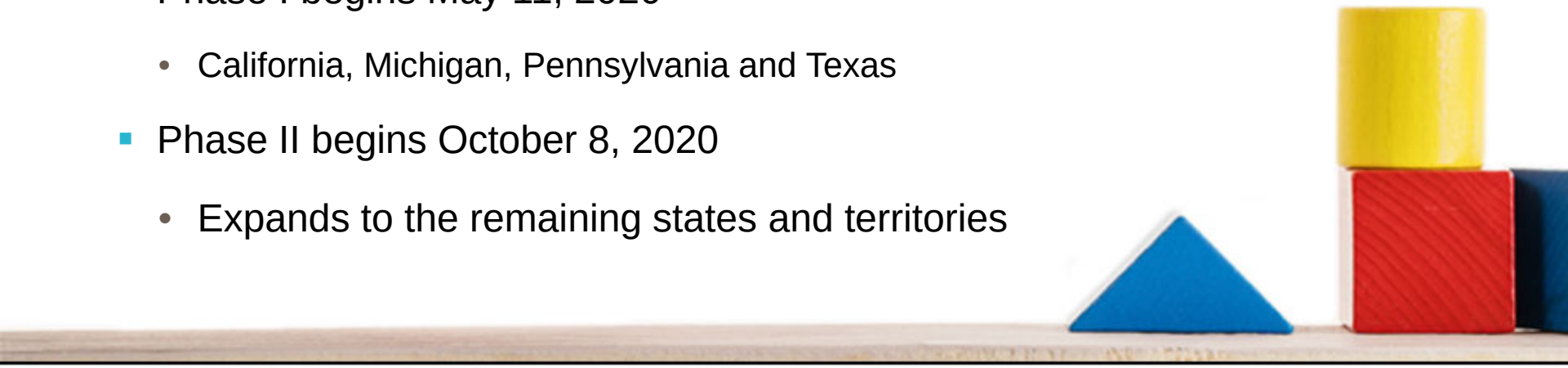
- CMS has added the following five Group 2 HCPCS codes for Pressure Reducing Support Surface (PRRS) to the Required Prior Authorization List:
  - E0193
  - E0277
  - E0371
  - E0372
  - E0373
- Prior authorization of these codes is required nationwide for date of delivery on and after October 21, 2019.



Condition of Payment Prior Authorization

Lower Limb Prosthetics

- CMS has added the following six Group 2 HCPCS codes for Lower Limb Prosthetics (LLP) to the Required Prior Authorization List:
  - L5856
  - L5857
  - L5858
  - L5973
  - L5980
  - L5987
- Phase I begins May 11, 2020
  - California, Michigan, Pennsylvania and Texas
- Phase II begins October 8, 2020
  - Expands to the remaining states and territories



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

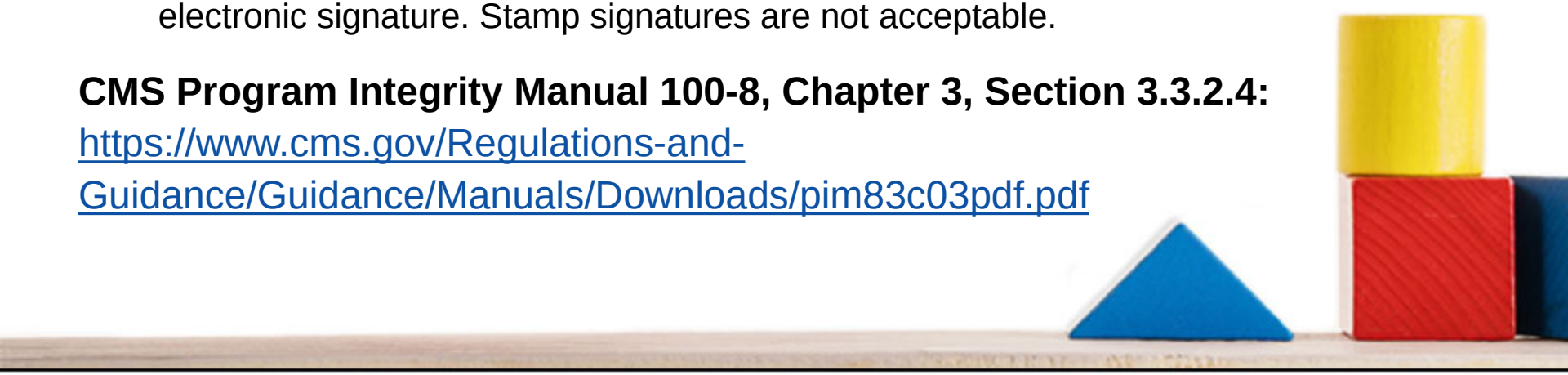
Physician and Treating Practitioner Signatures

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

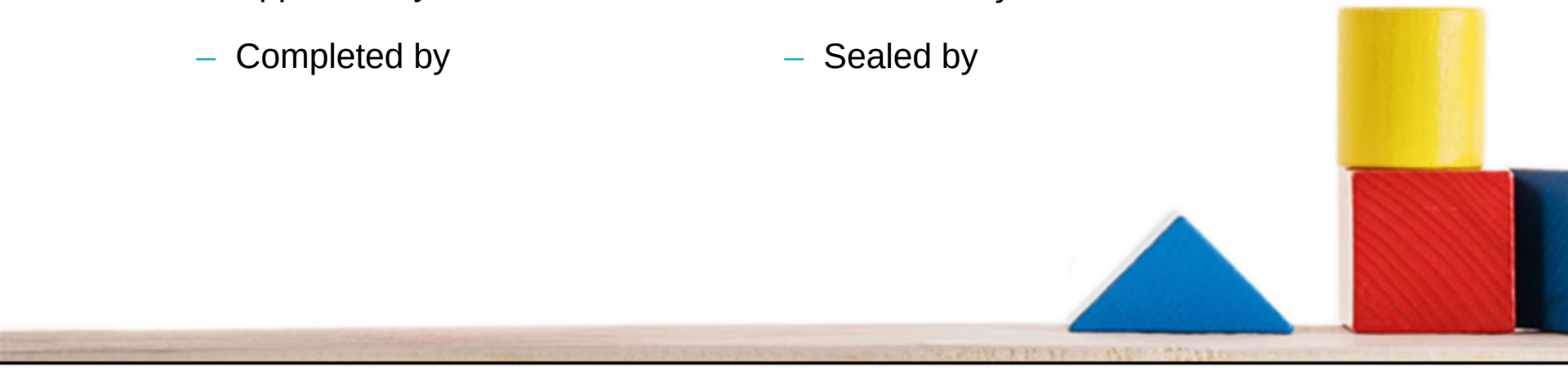


Handwritten Signatures

- 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

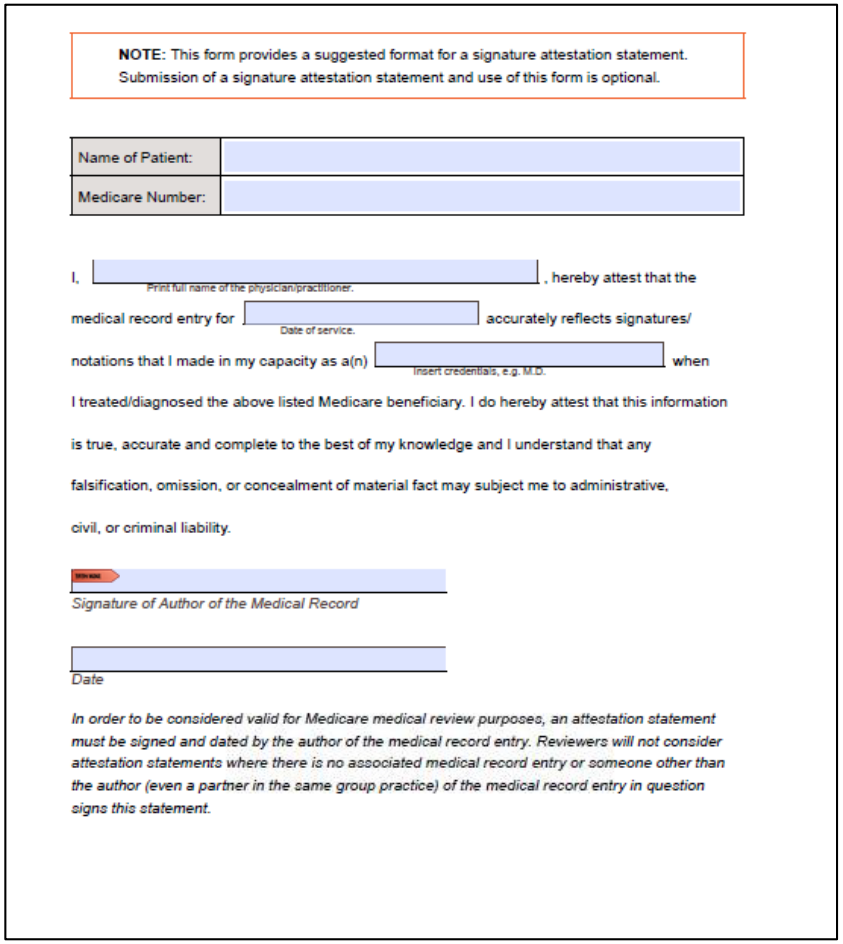
Medicare requires a legible identifier for services provided/ordered

- 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	Dr. John Smith/JS M.D.	M.D.

- 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.

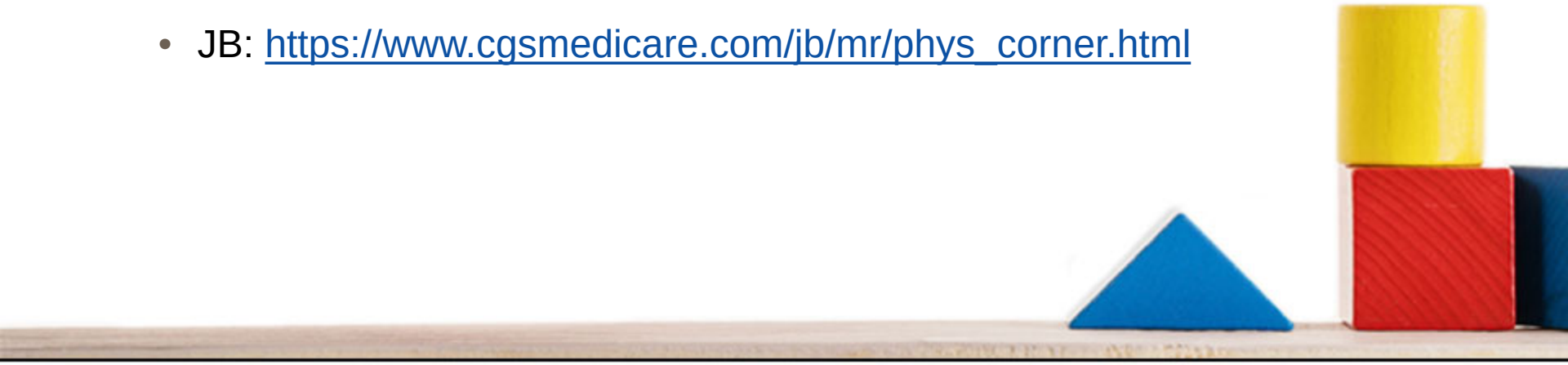
DMEPOS Documentation Requirements

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

Practitioner Documentation Resources

Condition of Payment Prior Authorization

- A prior authorization submission form is available at:
  - JB: https://www.cgsmedicare.com/jb/mr/pdf/condition_of_payment_prior_auth.pdf
- Additional information and resources are available at:
  - JB: https://www.cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html
- Prior Authorization Process for Certain DMEPOS Items
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items

Questions

Thank you for attending!