Documents Required in the Patient's File

Sept.2018

Efficiency and Accountability

Being Proactive = Faster delivery + Patient Compliance (Satisfaction)

Being Reactive = Costs time + $$$

Implement a Protocol for Successful Reimbursement

- Ensure everyone involved understands the requirements and are acting in the best interested of the company
- Assign someone within as the final decision (give them the authority to make these decisions without question)
- Set rules --- identify any gray areas, make non-negotiable requirements
- Making sure all understand policies (consider Medicare policy for all payers)
- PROACTIVELY ADDRESS COMPETING FORCES WITHIN (clinical vs billing/intake)
- Don't allow delivery until all requirements are met
- Changing corporate culture starts with leadership
- And stop saying, "we've always done it that way" – time to adapt to change

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Important Note: CGS does not house LCDs on our website. By clicking some o

- Active/Current LCDs EXT
- Active/Current Articles EXT
- Future LCDs – Future effective dates EXT
- Future Articles – Future effective dates EXT
- New Draft LCDs
- Draft LCDs EXT
- Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) EXT

Who can order DME?

The ordering practitioner can be:

- Physician
- Nurse practitioner
- Physician assistant
- Clinical nurse specialist

BUT: Must have own NPI & must be allowed to practice medicine in the state they are treating the patient for the condition the item is being provided for.

AND: They are practicing under the supervision of a doctor of medicine or doctor of osteopathy

PIM 5.7- Documentation

"For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type & quantity of items ordered & for the frequency of use or replacement (if applicable). ----- However, neither a physician's order nor a CMN nor a DIF nor a physician attestation statement by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier."

PIM= Program Integrity Manual: CMS online manual

What is Needed In Patient Files

- ❑ Patient Profile: Order Intake Form
- ❑ Verification of current & permanent address
- ❑ Insurance information – primary and secondary (copies of cards)
- ❑ Attending practitioner's full name, address, NPI
- ❑ Dispensing Order/Preliminary Order
- ❑ Detailed written order
- ❑ Medical records – office visit
- ❑ Any other necessary supporting documentation
- ❑ Assignment of Benefits (AOB)
- ❑ Proof of delivery
- ❑ Proof of warranty information reviewed
- ❑ Review of HIPAA, Privacy rules, supplier standards

Additional Information – If Applicable

- ✓ Representative information, if patient did not sign
- ✓ ABN
- ✓ Certificate of Medical Necessity (CMN)/ DIF
- ✓ Purchase Option Letter
- ✓ Power of attorney (POA)
- ✓ Supplier Standards
- ✓ Patient Bill of Rights

ACA 6407 Face to Face Ruling

Effective July 1, 2013

Medicare will require that specific items of DME will require:

1. Detailed Written Order Prior to Delivery
2. Face to Face (F2F) encounter completed by ordering practitioner

"PRIOR TO DELIVERY"

What does this mean…

- A referral must document and communicate to the DME supplier that a F2F encounter with the beneficiary by the physician or NP or PA or CNS.
- Which means you have to have documentation that a face to face with the ordering practitioner occurred within 6 months prior to date of detailed order.
- The Physician no longer needs to co-sign the F2F evaluation if performed by NP or PA or CNS. (announcement released 9-9-15)
- Must be signed and dated by ordering practitioner & include NPI
- Make sure you date stamp the order and medical records
- **The Supplier can complete the detailed written order, then have the ordering practitioner review, sign, and date.**

"The List"

List includes 164 HCPCS Codes

Some of the main items include:

- Oxygen and related equipment
- All Manual Wheelchairs & accessories
- All Hospital Beds & accessories included heavy duty beds
- Overlays
- TENS Units
- Rollabout Chairs
- Blood Glucose Monitors
- Traction-Cervical Equipment
- Ventilators
- PAP and RAD devices
- All Nebulizers
- Seat Lift Mechanisms
- And other items

DWO and F2F Errors -before delivery

On August 7, 2014 a new update was released:

I. If errors in the DWO & F2F evaluation are <u>found prior to delivery</u>, the supplier has two options:

A. The DWO or F2F may be properly amended following the guidance in the Program Integrity Manual (Internet-Only Manual, Publ. 100-08), Chapter 3, Section 3.3.2.5; or,

B. A new DWO or F2F may be created and sent to the physician for signature and date.

DWO and F2F Errors- after delivery

II. If errors in the DWO & F2F evaluation are found after delivery of the item, the supplier has two options:

A. If the error is discovered **prior to claim submission**, the original supplier may recover the delivered item(s), obtain a compliant, complete DWO, F2F and then may re-deliver the item(s) to the beneficiary; or,

B. If the error is discovered **after submitting a claim**, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements.

Comparison Written Dispensing vs. Detailed Written Order

Dispensing Order (or 5 Element Order)

- Beneficiary's name
- Physician's name
- Date of the order (which should be the date the supplier is contacted by the physician)
- Description of the item
- Physician's signature

Detailed Written Order (DWO)

A detailed written order (DWO) is required before billing. Someone other than the prescribing practitioner may produce the DWO. However, the prescribing practitioner must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Prescribing practitioner's name
- Date of the order
- **All items, options, or additional features that are separately billed or require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, a HCPCS code narrative, or a brand name/model number**
- Prescribing practitioner's signature and signature date

- **We highly recommend narrative description – best practice.**

Updated: Winter Supplier Manual Chapter 3 (01-02-18)

DWO

A detailed written order (DWO) is required before billing. Someone other than the prescribing practitioner may produce the DWO. However, the prescribing practitioner must review the content and sign and date the document.

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the **"Date of the order"** described above (previous slides), use the dispensing order date i.e., the date the supplier was contacted by the prescribing physician (for verbal orders) or the date entered by the prescribing physician (for written dispensing orders).

Additional order date instructions:

- If the prescriber creates the DWO, only a single date - the "order date" - is required. This order date may be the date that the prescriber signs the document.
- If someone other than the prescriber (e.g., DME supplier) creates the DWO then the prescription must be reviewed and, "…personally signed and dated…" by the prescriber. In this scenario, two dates are required: an "order date" and a prescriber-entered "signature date".

Medical Records

Must contain at minimum:

- Patient name
- Date of encounter
- Sufficient documentation of 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
- Physician signature and date

Should Contain:

- Patient's diagnosis
- Pertinent information including but not limited to:
  - Duration of patient's condition
  - Clinical course
  - Prognosis, nature and extent of functional limitation
  - Other therapeutic interventions and results
  - Past experience with related items

➢Use the SOAP format or H&P

Get AND Use Supporting Documentation

Documentation has to be in progress notes

- In ADDITION to---Get Supporting Documentation –
- **USE:**
  - PT/OT evaluations,
  - Prosthetist/Orthotist,
  - Nursing notes
  - Home health notes
  - Hospital discharge notes
  - SNF notes
  - Any other clinical notes, lab tests, dietician

What is NOT a Medical Record

- Supplier created forms (even if completed by the physician and included in chart)
- Attestation statements signed by physician
- After-the-fact letters from physician to supplier
- Certificates of Medical Necessity not mandated by CMS
- Orders – Avoid putting medical necessity information on orders

PURCHASE / RENT OPTION LETTER
FOR POWER WHEELCHAIRS AND ACCESSORIES

If you meet the Medicare coverage criteria for a power wheelchair prescribed by your physician, Medicare may help pay for it. Upon delivery of the power wheelchair, Medicare requires _____to give you the option of either purchasing or renting the power wheelchair and certain accessories.

If you choose to purchase the power wheelchair and the accessories, upon approval, Medicare pays 80 percent of the allowed purchase price in a lump sum amount. You are responsible for the 20 percent coinsurance amounts and, for non-assigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, you must elect to purchase the power wheelchair and the accessories at the time your medical equipment supplier furnishes you the item.

If you choose to rent the power wheelchair and the accessories and the Medicare coverage criteria are met, Medicare may pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the power wheelchair and accessories is transferred to you. During the rental period, you will be responsible for the 20 percent coinsurance payment for each month of the rental period, and for non-assigned claims: you will be responsible for the balance between the Medicare allowed amount and the supplier's charge. Medicare requires _____ to convert your rental agreement to a purchase agreement after 13 months of rental. This means once Medicare has made the final 13th rental payment, title to the equipment is transferred to you and you will own the equipment.

Once the power wheelchair and accessories are purchased, you are responsible for 20 percent of the service charge each time your equipment is actually serviced or repaired and, for non-assigned claims, the balance between the Medicare allowed amount and the supplier's charge.

You are receiving the following items. Please indicate below your selection to either purchase or rent the wheelchair and all related accessories listed below.

Items:

Option: ☐ Purchase ☐ Rental

Beneficiary Signature: _____Date: _____

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

ABN – Advance Beneficiary Notice of Non-Coverage (Of DENIAL)

- An Advance Beneficiary Notice (ABN) is a written notice that suppliers may give to a Medicare beneficiary before providing items and/or services that Medicare otherwise might NOT pay for
  - Lack of medical necessity
  - Same / similar denial
  - Upgrade
  - Quantities exceed allowed amount
- The ABN allows the beneficiary to make an informed consumer decision as to whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance
- **SPEAKS to the beneficiary**

Acceptable ABN

- Be on the approved form CMS-R-131 (Exp. 03/2020)
- Clearly identity supplier name, address, and telephone number (A)
- Clearly identify the beneficiary (B)
- Identification Number (C) Field is optional and can include identifier such as medical record number or date of birth
  - Medicare numbers, HICNs, or social security numbers MUST NOT appear on the ABN
- Clearly identify the item and/or service
- State that supplier believes Medicare is likely (or certain) to deny payment for particular item and/or service
- Give reason for belief Medicare is likely (or certain)to deny payment for the item and/or service
- Give a reasonable estimated cost of non-covered item and/or service
- Be signed and dated by beneficiary or representative
- Once signed by beneficiary or representative may not be modified or revised

IF ABN signed at time of delivery, recommended to note time on ABN and delivery ticket – to prove prior to delivery.

Other Examples for Section E

Valid	Invalid
"The beneficiary does not have the required diagnosis to qualify for this item per the Medicare policy."	"Beneficiary might have similar equipment on file."
"The beneficiary currently has a standard wheelchair (K0002) paid for by Medicare on 12/2/2009 which is same or similar to this power wheelchair (K0823)."	"Medicare may not pay for this item."
	"Beneficiary may not be eligible for Medicare Part B at this time."
	"Not enough supporting documentation in the medical record."

Proof of Delivery

Signed POD required to verify beneficiary received item

Requirements:

- Beneficiary's name
- Delivery address
  - If beneficiary picks up at store, make sure the delivery ticket as your address on it somewhere to indicate it's a pick-up in the store
- Detailed description to identify the item(s) being delivered
  - Brand name, serial #, narrative description
- Quantity delivered
- Date delivered
- Beneficiary signature
- Supplier signature

Can be signed by:

- Beneficiary designee
- Beneficiary's designee – relationship to beneficiary must be noted on delivery slip

Who can sign POD record?

A designee is defined as:

"Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

- Legal guardian
- Representative payee—a person designated by the Social Security Administration or other governmental agency to receive an incapable beneficiary's monthly cash benefits
- Authorized representative—acts on behalf and in best interest of the beneficiary and is usually a parent, legal guardian of minor, or legal guardian of an adult who has been declared incompetent
- Designee
- Relative
- Friend
- Representative of an institution providing care or support
- Governmental agency providing assistance

The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier.

The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary.

Delivery via Shipping or Delivery Service Directly to a Beneficiary

The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, your invoice number, or alternative method that links your delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered.
- Quantity delivered
- Date delivered
- Evidence of delivery

If you utilize a shipping service or mail order, you must use the shipping date as the DOS on the claim.

The shipping date may be defined as the date the delivery/shipping service label is created or the date the item is retrieved for delivery. However, such dates should not demonstrate significant variation.

Updated: Winter Supplier Manual Chapter 3 (01-02-18)

Delivery via Shipping or Delivery Service Directly to a Beneficiary

POD documentation must be a complete record tracking the item(s) from you to the beneficiary.

An example of acceptable proof of delivery would include both your detailed shipping invoice and the delivery service's tracking information. Your record must be linked to the delivery service record by some clear method like the delivery service's package identification number or your invoice number for the package sent to the beneficiary.

Store this in YOUR Files – DO NOT RELY on the shipping services to store – IT WILL BE GONE and SOON

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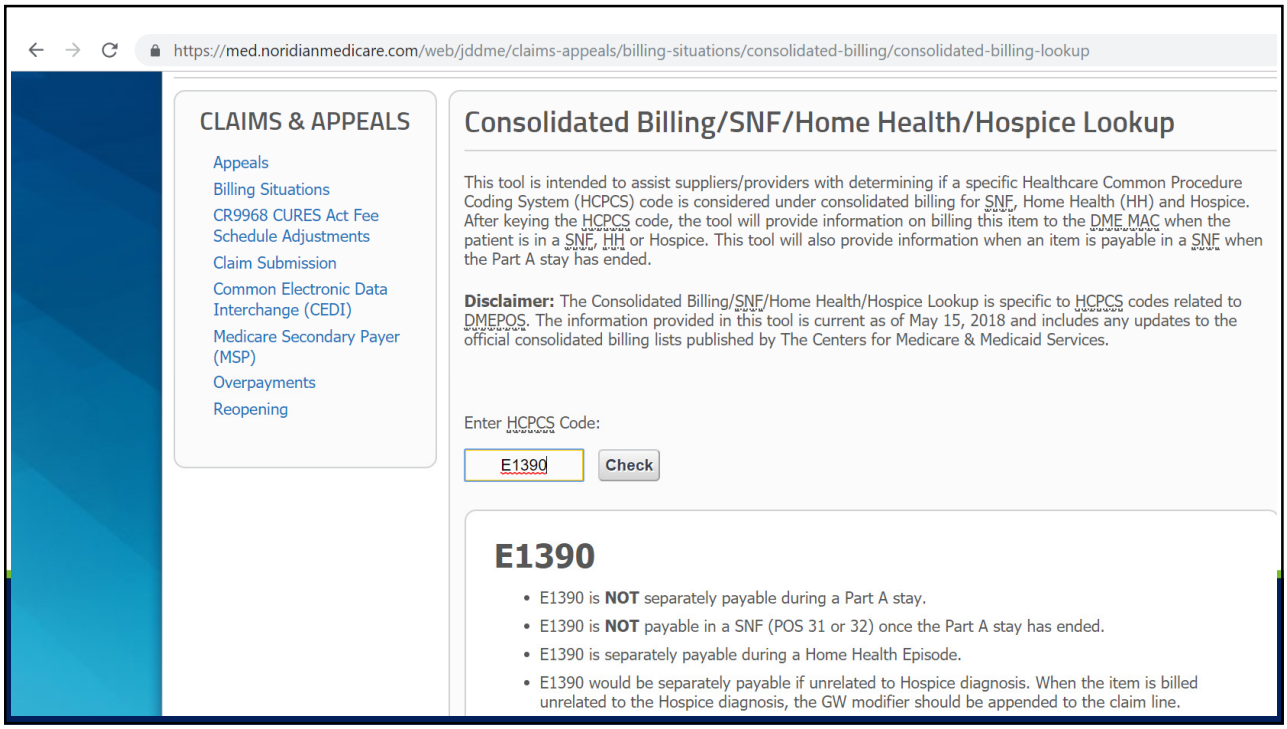
Delivery to Hospital/SNF

- Delivery can be up to two days prior to discharge if it is for the ****benefit of**** fitting or training, date of discharge is the date of service
- Hospital/SNF/Rehab discharge date is date of service
- The date of service can not be earlier than date of delivery
- Need a narrative in the NTE section of claim with discharge date

Maintaining Documentation

- Documentation must be maintained in the supplier's files for seven (7) years from date of service.
- If the provider responds, in writing, that the Medicare qualifying supplier documentation is older than 7 years, and provides proof of continued use/continued need the contractors shall not deny the claim based solely on missing the supporting Medicare qualifying documentation that is over 7 years old.

PIM, Chapter 5, Section 5.8



Legibility and attestation statement

- **ALL** Signatures must be legible –physician and supplier
- No DATE STAMP signatures and dates
- If electronic signature and date, make sure it indicates such
- Use a signature log, if needed
- Use attestation statement

  "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 _____[insert provider 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."

- If you can't read a note, more than likely no one else can either---ask physician to transcribe note, the nurse is able to transcribe as well—have physician sign and date transcription

Corrections to a Document

- All clinical documents are part of the medical record
- Corrections must adhere to Medicare policy:
  - Original text should not be deleted/obscured
  - ***Single line*** should go through incorrect text/data
  - The change must be clearly identified as a correction
  - The change must be ***signed/initialed and dated*** by the author at the time of the correction
  - Must be a change or information that could reasonably be added without having the patient present
  - Must be information or data that could be reasonably recalled in the time since the in-person visit
    - Recommend it is added within 30 days of the exam

Example of a Correction

- **<u>Original text in the document:</u>**

  The patient had an oxygen saturation of 88% on room air at rest.

- **ACCEPTABLE**:

  Error 88% John Doe, MD 9/3/18

  The patient had an oxygen saturation of ~~98%~~ on room air at rest.

- <u>UNACCEPTABLE</u>:

  88%

  The patient had an oxygen saturation of ~~98%~~ on room air at rest.

- <u>UNACCEPTABLE</u>:

  The patient had an oxygen saturation of **88%** on room air at rest.

Continued Need vs Continued Use

- **Continued Need**
  - For ongoing supplies and rented DME items, in addition to information justifying the initial need of the items and/or supplies, there must be information in the medical record to support that the item continues to remain reasonable and necessary
  - A recent order by the treating physician for refills (within the past 12 months)
  - A recent change in prescription
  - A properly completed CMN with an appropriate length of need specified
  - Timely documentation in the beneficiary's medical record showing usage of the item (within the past 12 months)

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Continued Need vs Continued Use

- **Continued Use**
  - The ongoing utilization of supplies or a rented item by a beneficiary
  - Suppliers are responsible for monitoring utilization of rental items and supplies
  - Monitoring of purchased items or capped rental items that have converted to a purchase is not required
  - Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary
  - Timely documentation in the medical record showing usage of the item, related option/accessories, and supplies
  - Refill request
  - Supplier records documenting beneficiary confirmation of continued use of a rental item

Proactive

- Education to staff – referral sources – beneficiaries
- Good order intake - CSRs
- Medical Records – Get them and **READ** THEM!
- Clinical documentation (supporting) is important from all sources
- Use the documentation checklist as flow sheets
- Use billing software to add red flags (stops) for key information
- Review medical policies (LCD) and articles (regularly)
- Files need to be legible and in order
- **ALL** Signatures must be legible
- DATE STAMP when received
- Self Audits are a **must** –do yourself or have outside party
- **Billing should NOT be reactive to Intake**

- Team of expert consultants providing…
  - Prescreen Reviews
  - Forms and Documentation Reviews
  - Proactive Claim Audits
  - On-going compliance support packages
  - "Any willing provider" prep kit (1 hr product-specific webinar for staff and 1 hr documentation/form review = $399 for VGM Members)
  - TPE/RAC/UPIC Audit support and appeal preparation

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Oct 2nd at 10am central
Looking at Getting Into Oxygen Services? Let's Discuss the Oxygen Policy First
https://attendee.gotowebinar.com/register/7790106246305997313

Oct 9th at 11am central
PMD Documentation Requirements
https://attendee.gotowebinar.com/register/2423198676217400067

Oct 24th at 10am central
Digging Into CPAP Policy Requirements
https://attendee.gotowebinar.com/register/4577193631967896321

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