Meeting/Question and Answer Summary

Meeting Summary
On December 14, 2011 the Comprehensive Error Rate Testing (CERT) Task Force conducted two webinars over documentation for the supplier community. The purpose of these sessions is for the CERT Task Force to provide the supplier community education regarding the documentation requirements and CERT additional documentation requests (ADR).

Question and Answer Summary

Previously Submitted Questions

CERT:

Q1. Is it cost effective to have both Livanta and Advance Med involved in the collection and review of CERT request? Why not have one unit collect and review?

Answer: This is a Centers for Medicare & Medicaid (CMS) directive and the workload is currently contracted by CMS as two separate contracts. The CERT Documentation contractor is responsible for tracking CERT documentation requests and receipts, while the CERT Review contractor is responsible for review of the incoming documentation against existing Medicare guidelines.

Q2. What is the address to mail CERT requests to? Why is the National Supplier Clearinghouse (NSC) address on file for the PTAN/NPI not used? Can this address be changed by anyone who calls and requests that it be changed even if they are not authorized to do so?

Answer: Suppliers have the ability to designate an address to which all CERT requests should be sent. These updates may be made online at: https://www.certprovider.com/ProviderDirectory.aspx. The request will give suppliers the information; however, the preferred method for receipt of medical records or documentation is via fax: 240-568-6222.

The updates or corrections made through the CERT Documentation Contractor (CDC) only change CDC’s records and are mainly for obtaining medical record documentation to support claims review. All revisions involving contacts and/or addresses and phone numbers, will not affect the information on record with the CMS provider enrollment office or the DME MAC contractors’ provider files.
Q3. Some suppliers have not been receiving the CERT requests in a timely manner. The letter is dated two weeks later than the date it was mailed out, what can be done to correct this?

Answer: This is not a known issue. Please report these instances immediately to your durable medical equipment Medicare administrative contractor (DME MAC) and the CERT contractor as they occur so the issue can be tracked and resolved.

Q4. What are the phone number suppliers should call in order to receive an extension on a CERT review?

Answer: Extension requests are accepted by phone only at: 1.888.779.7477 or 1.301.957.2380.

Q5. How strongly is CMS/CERT explaining to physicians that their medical records/progress notes must be legible and signed & dated?

Answer: The CERT program is national in scope, and all Medicare contractors are tasked with reducing the error rate in their respective jurisdictions. Education based on CERT findings is a primary component of all contractors’ educational programs, extending to physician education conducted by the A/B MACs.

Q6. Can one obtain their provider specific error rate?

Answer: Suppliers are encouraged to work with their Medicare contractor for supplier-specific errors. In general, contractors are able to provide the number of times a supplier has been audited and the results of each.

Q7. This is a general question regarding CERT. Why did we get such a large volume of CERT withdrawal requests? Are there a certain number of requests that each supplier is required to respond to?

Answer: Suppliers should respond to all CERT requests timely to avoid unnecessary and costly errors. Occasionally, a withdrawal request may be issued, but these instances are rare.

Q8. What is the maximum number of CERT requests a supplier should receive in a given month?

Answer: Because the CERT audit process is random, there are no thresholds for minimum or maximum number of requests in a designated period of time.

Q9. If the majority of items requested in the CERT letter are submitted to Medicare prior to the deadline date, what are the repercussions of submitting additional docs after the deadline, even if it is 1-2 days after the deadline?
Answer: If any required piece of documentation is missing, it could cause the entire claim to deny. If you are unable to gather all required documentation prior to the deadline, you may consider requesting an extension.

Q10. If CERT denies a claim how does a supplier know the exact reason for denial? Can the supplier speak with the CERT reviewer? If yes, what is the phone number?

Answer: Suppliers will be notified of their CERT denials through the overpayment recovery process. You will receive a letter requesting a repayment of the dollars paid in error from your Medicare contractor. This letter will provide a brief explanation of the reason for the denial. If you require additional information, your Medicare contractor will be able to provide more detail.

Q11. We are getting tons of CO-50 denials as result of us not responding to audit letters. However, we are not receiving the letters in many cases. We checked and our address of record is correct. Is anyone else having this problem?

Answer: This is not a known issue. Suppliers would be advised to work with the NSC and the CERT contractor to ensure all mailing addresses are current and accurately noted.

Q12. When suppliers respond to CERT requests via fax will they receive immediate confirmation the documentation was received?

Answer: Yes, you should receive a confirmation when you fax documentation for a CERT audit.

Q13. What percentages of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims are audited?

Answer: Approximately 50,000 Medicare claims are randomly audited through the CERT program each year. This sample of claims is evenly distributed among all Medicare contractors who process claims for the Medicare Program.

**Detailed Written Orders:**

Q1. Are digitally signed electronic prescriptions (sure script) allowed by Medicare?

Answer: Yes

Q2. Can a physician who works as a hospitalist write an order for DME?

Answer: Yes.

Q3. If the physician assistant (PA) sees a patient but the physician does not the day the order was placed, can the physician sign the certificate of medical necessity (CMN) or does it have to be the PA?
Answer: The CMN should be signed by the person listed in Section A. Someone different can complete the questions as long as their name is noted at the bottom of section B.

Q4. Physician assistants also have NPI numbers however billing is under the physician name. In the case of a nurse practitioner must we still bill under the physician name if we do not know if they bill for their services to Medicare?

Answer: Nurse Practitioners and Clinical Nurse Specialists must be practicing independently of physicians and claims should be billed under the NP’s or CNS’ name.

Q5. Does a detailed written order have to include the HCPCS code?

Answer: The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

Q6. Under acceptable formats, please define "electronically maintained" as it pertains to e-scripts?

Answer: Medicare reviewers shall accept as a valid order any drugs incident to durable medical equipment (DME), other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to [http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf](http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf) on the Internet.

Q7. Does a walker or commode billed as a sale need a length of need?

Answer: No.

Q8. We often fax over a detailed prescriptions for prosthetics to the ordering physician. These will be on our prescription pads, not the physicians. Would we need a Signature Attestation for the prescribing physician when sending in a CERT audit?

Answer: With the exception of Power Mobility Devices, someone other than the physician may complete the detailed written order; however, the treating physician must review the details and personally sign and date (handwritten or electronic only—stamped signatures and dates signature and date stamps are not acceptable) the order to indicate agreement.

Q9. Is frequency only necessary on Detailed Written Orders if the local coverage determination (LCD) specifically requires it to be documented?
**Answer:** In addition to LCD specifications, if the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need (for example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month or until the ulcer heals).

Q10. If a supplier has oxygen CMN, change of physician from the original order from hospitalist, is the CMN good for one year? The recertification comes from the PCD at one year; do suppliers need to get a new initial from the primary care physician (PCP) prior to the one year?

**Answer:** A revised CMN is needed when there is a change in the treating physician but the original oxygen order stayed the same.

Q11. We require a new prescription every 6 months. Does this adequately cover the documentation requirements for continued need?

**Answer:** The new documentation language that is being incorporated into each of the policies provides direction on what can be used for continued need.

For ongoing supplies and rental durable medical equipment (DME) items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DME Information Form (DIF) with an appropriate length of need specified
- Timely documentation in the beneficiary’s medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

Q12. If physician completes an electronic prescription but attaches a pen and ink signature to the prescription, can we accept even though the date was electronically attached to the prescription? To clarify, physician signs but date signed is assigned by electronic prescription protocol. Can we accept as a valid detailed written order?

**Answer:** Yes.

Q13. Can a pharmacist place an order for the patient?
Answer: No. A treating physician must complete an order for a patient. Per the CMS IOM 100-01, chapter 5, section 70 “Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection §70.2 ), doctor of podiatric medicine (within the limitations in subsection §70.3), or doctor of optometry (within the limitations of subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.”

Q14. If length of need or physician changes for an Enteral patient, do we need a revised DIF in addition to the new refill order?

Answer: Yes.

Q15. Regarding Orders: Does the physician have to date the order himself/herself or can it be dated by the health care team?

Answer: The signature date of the physician must be dated by the physician. Other dates included on the order may be completed by other individuals.

Q16. If we are getting clinic soap notes and the physician signs it electronically is that ok or do they need to physically sign it?

Answer: Electronic signatures are acceptable as long as there is an indication the documents are being electronically signed, the name of the person executing the signature, and the date of the electronic signature.

Q17. If the physician writes an order and dates it at the top of the order, does he need to date the order again when he signs at the bottom?

Answer: Yes.

Q18. How can we obtain a signature log?

Answer: Medicare does not have a required format for signature logs. Signature logs can be created by the supplier. CMS has provided some suggested language for attestation statements.

Should a provider choose to submit an attestation statement, they may choose to use the following 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 the physician’s signature is missing from the order, the order is considered invalid. Signature logs and attestation statements can only be used for orders when the physician’s signature is illegible and the printed physician name is missing from the order.

Q19. Must the "verbal" order pertain to specific item being dispensed such as immunosuppresives?

Answer: Yes.

Q20. If the initial order comes from the PCP and the beneficiary change comes to a different physician in same group, do we need a revised DME information form (DIF)?

Answer: Yes.

Q21. If company A purchases/acquires company B, can company A use company B’s written order to send subsequent orders?

Answer: No. This would be a change in suppliers and a new order is required.

Q22. What do we do if we receive a dispensing order from a Home Health and there is no physician signature or medical documentation from physician?

Answer: An order from the treating physician is necessary to dispense and bill items to Medicare. If a detailed written order is not obtained before Medicare is billed, the EY modifier should be added to all HCPCS codes for which an order was not received.

Q23. How do we handle Physical Therapist orders for a patient who is being discharged from the hospital but there is no physician signature or no clear documentation the physician ordered the item?

Answer: An order from the treating physician is necessary to dispense and bill items to Medicare. If a detailed written order is not obtained before Medicare is billed, the EY modifier should be added to all healthcare common procedure coding system (HCPCS) codes for which an order was not received.

Q24. For a 5-year reasonable useful lifetime (RUL) for Oxygen, do we need to get a new order and follow up with a CMN? Or does CMN take place of an order?

Answer: When the 5-year RUL is reached and the beneficiary requests new equipment, only a new Initial oxygen CMN is required unless the treating physician changes the original order.
Q25. If a patient comes in with a prescription for a back brace for post-op use 3 weeks prior to surgery, who is responsible for payment, the hospital or Medicare?

Answer: In order to be billed to the DME MAC, the brace must be for home use. If the brace is being delivered to the patient or hospital for use at home after the surgery, it may be used only for fitting and training purposes and delivered no sooner than 2 days prior to the beneficiary being discharged to home. If the brace is being provided to the beneficiary for use immediately post-operatively or during the inpatient stay to stabilize the spine in the post-surgical period, the brace must be billed to the hospital, not the DME MAC.

Q26. Is a signed verbal order not a qualified medical record?

Answer: Orders, preliminary and/or detailed written, are not considered medical records.

Q27. When billing Medicare for a denial, is the supplier required to complete all the documentation requirements of a payable service? E.g., prepare a DIF and detailed written order?

Answer: Yes. All Medicare billing rules must be met for all claims billed.

Q28. If a company was purchased by another company but is still operating under the original company name/NPI, do we need to obtain a new order for the date that the new company purchased the other company?

Answer: No.

Q29. For PMD, on the DWO does it have to have make, model and charge?

Answer: No. A PMD requires a 7-element order and detailed product description (DPD). The DPD has the same requirements as a detailed written order. While make, model and charge are not required on the DPD, suppliers should put as much details as possible on the DPD so that contractor review staff can determine that the item(s) dispensed is properly coded.

Q30. For enteral feeding, when a resident has an increase or decrease in nutrition administration rate only, does the entire detailed written order (all supplies listed) need to be re-written, or is the administration rate and nutrition being used enough?

Answer: A completely new detailed written order is needed.

Q31. Is a detailed written order a prescription?
Answer: Yes. The detailed written order may serve as a dispensing order – or prescription – as long as it obtained prior to dispensing/delivery of the item. However, a dispensing order may not necessarily contain sufficient information to satisfy the requirements of a DWO.

Q32. Can we complete a written order in full and send it to the prescribing practitioner for review and signature?

Answer: Yes. If the item was dispensed based on a verbal order then the supplier can complete the order and send to the physician to review, sign, and date. The exception to this rule is the requirement that the treating physician complete all elements of the 7-element order for a Power Mobility Device.

Q33. Is a written order for equipment only good for 30 days?

Answer: An order is valid based on the length of need determined by the treating physician. If the physician indicates a length of need for 30 days then the order is only valid for 30 days unless one of the other new order requirements have been met.

Q34. Do we need a new prescription if the chart notes to support the prescription are after the date on the prescription but before the date of service?

Answer: For all DMEPOS items, the initial medical need or justification is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are formed prior to the creation of the initial order. For a purchased item, the initial months of a rental item, or for ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Information from the beneficiary’s medical record must have been created prior to the initial date of service (DOS) to establish whether reimbursement was justified based upon the applicable coverage policy.

Q35. What level of detail is needed on a Detailed Written Order for diabetic shoes & inserts?

Answer: The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description or a brand name/model number. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

An order must be obtained prior to claim submission and must contain the following:

- Beneficiary name
- Prescribing physician’s name
- Detailed description of the item(s) to be provided
  - If custom item is provided, the order must state “custom”
  - Modifications
- Quantity dispensed
Prescribing physician’s signature and date order signed
  o Signature and date stamps are not acceptable
• Start date of order (if the start date is different than the signature date)

Note: The detailed written order must be signed on or after the date of the visit with the prescribing physician.
A detailed written order for some durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) items may indicate “lifetime” and a new order is not routinely (i.e., quarterly, annually, etc.) required. However, when billing therapeutic shoes for persons with diabetes a new order is required if:
• A shoe needs to be replaced
• A modification or insert needs to be replaced more than one year from the most recent order on file

Q36. Is there a separate form other than the prescribing physician’s prescription where the physician states that patient needs diabetic extra depth shoes & inserts?

Answer: No. However, if the prescribing physician is the supplier, a separate order is not required, but the items provided must be clearly noted in the patient’s record.

Q37. Do we need both a dispensing and a written order?

Answer: No. A dispensing order is needed only when items are dispensed prior to a detailed written order being obtained. A detailed written order is needed prior to billing Medicare for the items provided. However, some items do require a detailed written order prior to delivery. Refer to the CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, 5.2.3.1 for a complete list of items that require a detailed written order prior to delivery.

Q38. Is a verbal order sufficient to dispense medical equipment along with a CMN or detailed written order?

Answer: Most items may be dispensed based on a verbal order. However, certain items require a DWO prior to delivery/dispensing. A detailed written order prior to delivery is required for the following:
• Pressure reducing support surfaces (group 1, 2, and 3), including mattress overlays, air-fluidized beds, and mattresses
• Seat lift mechanisms
• Transcutaneous electrical nerve stimulation (TENS) units
• Power operated vehicles
• Power wheelchairs
• Wheelchair seating
• Negative pressure wound therapy pumps
Suppliers may utilize the completed and physician-signed CMN to serve as the detailed written order for items which require a CMN and detailed written order prior to delivery (i.e., TENS, seat lift mechanisms). However, the CMN must be signed and dated prior to delivery of the item. Otherwise, a separate detailed written order in addition to a subsequently completed and signed CMN would be necessary.

**Q39. Can a nurse practitioner sign & date the written order?**

**Answer:** Yes.

**Q40. If we have a prescription and order detail form signed by the physician, can progress notes be provided by the physician to the supplier after the delivery date?**

**Answer:** Yes.

**Q41. For diabetic shoes and custom inserts, when an order is started and the patient ends up in the hospital and/or skilled nursing facility can we use the start date to bill or do we have to start the order over?**

**Answer:** The date of service on the claim will be the date the items are delivered to the beneficiary. If there has been an extended period of time between the original order date and the delivery timeframe, it might be necessary to get a new order if the original order no longer meets the beneficiary’s medical need.

Also, a new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file.

**Q42. If we receive an order for a walking boot, do we also need to have progress notes from the physician in order to provide the item or is the prescription with the diagnosis enough?**

**Answer:** At a minimum, a dispensing order is required prior to delivery and a detailed written order is required prior to billing Medicare. Medical records, such as progress notes, must be available to Medicare upon request and should be obtained from the physician.

**Q43. With electronic medical records becoming the standard, what is the ruling about signatures on records, or should they be electronically signed?**

**Answer:** Both handwritten and electronic signatures are acceptable on medical records.

**Q44. If we receive a verbal modification to the initial physician's order for urological supplies, do we need to obtain an updated written order prior to dispensing the supplies?**
**Answer:** An updated detailed written order must be obtained prior to billing Medicare; however, urological supplies may be dispensed based on the revised verbal order.

**Q45.** We are a home infusion provider. If we get an order to provide IV antibiotics to a patient for 6 weeks, do we need to call them every time we ship their drug/supplies or are we covered with the 6 week prescription?

**Answer:** Items may not be shipped on a pre-determined basis, even at the request of the beneficiary. Please refer to the “Items Provided on a Recurring Basis and Request for Refill Requirements,” article posted by each Jurisdiction in August 2011.

**Q46.** Is the prescribing physician required to sign off and confirm a preliminary verbal order in addition to signing the detailed written order?

**Answer:** For Medicare purposes, verbal preliminary orders do not require a physician’s signature.

**Q47.** Do detailed written orders require a start date?

**Answer:** All orders must clearly specify the start date of the order (if the start date is different from the date of the order).

**Q48.** Is a detailed written order prior to delivery required for Group I, Group II, and Group III support surfaces used with hospital beds?

**Answer:** Yes.

**Q49.** If suppliers are providing a three month supply of an item, does the detailed written order need to specify that?

**Answer:** In addition to all other detailed written order requirements, it should include information on the quantity to be used, the frequency of use, and duration of need. The supplier may provide a three month supply of a supply, if the LCD allows for delivery of a three month supply.

**Q50.** If the verbal dispensing order indicates a specific manufacturer (i.e., One Touch) but the detailed written order doesn’t specify a manufacturer, are suppliers required to follow the verbal order and provide the specific manufacturer?

**Answer:** The supplier must accurately transcribe the information provided by the physician in the verbal order to the detailed written order. If the physician specifies a particular make or model of a device to be dispensed in the verbal order, that same specific make or model of device must be included on the detailed written order. If the supplier does not have that specific make or model in their inventory, the supplier must contact the physician’s office to determine if
another a specific brand/manufacturer will meet the beneficiary’s need. If the physician agrees to the substitution, this new brand or model would be included in the detailed written order. The supplier should also document in detail the interaction with the physician’s office and the change in product dispensed.

Q51. If suppliers have a signed and dated detailed written order prior to dispensing, is a separate dispensing order required?

Answer: No.

Q52. Does the detailed written order need to specify a manufacturer, brand name, etc.?

Answer: The specific manufacturer and/or brand name assists Medicare in determining if the appropriate HCPCS code has been billed. The detailed written order does not need to specify the manufacturer or brand name; however, the description must be specific enough for Medicare to determine if the appropriate HCPCS code was billed.

Q53. If a supplier obtains a signature log from the physician and the signature is still illegible, what do suppliers need to do?

Answer: The purpose of the signature log is to associate the physician’s printed name with their signature. The signature may still be illegible; however, the printed name must be legible.

Q54. Are signature logs required for every order or for each physician?

Answer: No, signature logs are not a requirement. Signature logs are a suggestion to associate an illegible signature on an order with the physician’s printed name.

Q55. Is an International Classification of Diseases (ICD-9) code required on orders? If so, can suppliers enter the ICD-9 code on the order?

Answer: ICD-9 codes are not required on orders. Suppliers are to obtain the appropriate diagnosis or ICD-9 from the physician.

Q56. How often are suppliers required to obtain an order for Continuous Positive Airway Pressure (CPAP) supplies?

Answer: A new prescription is needed when:
- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires periodic prescription renewal
Q57. On the detailed written order, what is required to satisfy the “detailed description of the item”? For example, hospital bed or semi-electric hospital bed with side rails and mattress.

Answer: The description of the items must be specific enough for Medicare contractors to determine if the appropriate HCPCS codes have been billed.

Q58. If an order is received advising CPAP and supplies, can a supplier list CPAP, humidifier, tubing, and mask and resend to the ordering physician for a signature?

Answer: Yes.

Q59. Where are the requirements for electronic signatures published as regulation or policy by CMS?

Answer: CMS has not published formal regulations regarding electronic signatures. However, Medicare contractors strongly recommend that an electronic signature include a notation such as one of the following (not all-inclusive):

- Electronically signed by
- Finalized by
- Authenticated by
- Signed by
- Approved by
- Validated by
- Completed by
- Sealed by

Q60. Can a claim be denied if the electronic signature on the supporting medical record or the Detailed Written Order doesn’t contain one of the prefix statements above?

Answer: Claims can be denied and/or payments recovered if it is not clear the records have been authenticated by the treating physician. When records are electronically signed, there should be something to differentiate the physician’s typed name versus the physician’s electronic signature. The examples mentioned in the presentation are not all inclusive, however they are examples of signature tags that can be used to differentiate the signature from the printed name.

Medical Records:

Q1. What is meant by “electronically maintained”?

Answer: Electronically maintained generally means that the supplier utilizes computerized documentation retention system (i.e. electronic patient files stored on a hard drive or secured network within an organization). In the event a billed claim has been pulled for an audit the supplier would still be able to print and/or submit the documentation requested.

Q2. Following a patient evaluation does the physician need to sign and approve the forms?
**Answer:** If the physician completes the patient evaluation, the evaluation should be in their normal narrative format. The documentation should at a minimum have the patient’s name, date of the evaluation, contain pertinent information regarding the visit, and be signed by the physician. If the evaluation is completed by another clinician, the treating physician should review and sign the evaluation if the physician concurs with the findings.

**Q3. Does medical record documentation from other entities need to be signed off by the ordering physician?**

**Answer:** As a general rule, No. Records from other healthcare providers not in the employ of the supplier are considered medical records as noted in the PIM Chapter 5.7. There are exceptions to this general rule such as the specific requirement in the power mobility device (PMD) LCD for face-to-face examinations referred to a physical or occupational therapist. There is also the scenario in the Therapeutic Shoes local coverage determination and related policy article that allows the certifying physician to “sign off” on records from the prescribing physician documenting a qualifying foot condition. (See Q37 in this document).

**Q4. For diabetic shoes, the Statement of Certifying Physician form is required in place of Certificate of Medical Necessity (CMN). Currently this form requires a MD or DO signature. If this form is similar to a CMN, why can’t a nurse practitioner (NP) sign this form but can sign a CMN?**

**Answer:** The Statement of Certifying Physician form is not a substitution for a CMN nor it is review under the same guidelines as a CMS approved CMN. The Medicare Benefit Policy Manual chapter 15, Section 140 Therapeutic Shoes for Individuals with Diabetes states that the need for diabetic shoes must be certified by a physician who is a doctor of medicine or a doctor of osteopathy and who is responsible for diagnosing and treating the patient’s diabetic systemic condition through a comprehensive plan of care. Therefore, a nurse practitioner is not authorized under Medicare guideline to order therapeutic shoes for individuals with diabetes. Note that the Statement of Certifying Physician form is a suggested form and is not mandated by CMS or the DME MACs. The information captured on the Statement of Ordering Physician form must be corroborated in the patient medical records.

**Q5. What is an attestation statement signed by physician?**

**Answer:** In the event a piece of documentation (such as a physician progress note) is missing a physician signature, the beneficiary’s supplier may submit a signature attestation statement authored by the physician whom failed to sign the medical record entry. In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information. Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
Q6. Medicare does not allow "after-the-fact" letters from the physician however the physician is not required to provide us with documentation until "after-the-fact" audit. How is a supplier to ensure that the physician has the medical records?

Answer: It is expected that suppliers work closely with the physicians and help them understand the policies and documentation requirements. It is a supplier’s business decision as when and how medical record information is secured to determine if the patient qualifies for the item being ordered.

Q7. Can progress notes/medical record documentation be electronically signed?

Answer: Yes. Medical records may be electronically signed and must be authenticated by the author making the medical record entry.

Q8. Although physicians have improved with documenting oxygen use in the chart notes, physicians have not always documented oxygen use at each visit with beneficiary. Why would a letter written by the physician after the fact which documents that the patient has needed and used the oxygen since set-up not be sufficient for Medicare?

Answer: The CMS Internet Only Manual (IOM) 100-08, Chapter 5 the Program Integrity Manual, section 5.7 states, “However, neither a physician’s order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).” Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. 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 and must contain sufficient information to identify the beneficiary.

Q9. On the continued need/use, what if the patient is not seeing their treating physician on a regular basis?

Answer: It is expected that for items ordered/billed documentation will be available to support the need. The CMS Internet Only Manual (IOM) 100-08, Chapter 5 the Program Integrity Manual, section 5.7 states, “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 and quantity of items ordered and for the frequency of use or replacement (if applicable).”

Q10. How often are you looking for ongoing need to be documented in physician charting?
**Answer:** For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary’s medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review.

Any of the following may serve as documentation justifying continued medical need:
1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary’s medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

**Q11. Would a nebulizer need recertification after purchased or only the drugs and supplies?**

**Answer:** Nebulizers and nebulizer drugs do not require a certificate of medical necessity (CMN) and therefore does not have any recertification requirements.

**Q12. If a physical therapist evaluates for a hand splint and the therapist signs the documentation, is the ordering physician also required to sign the documentation in order for it to be valid?**

**Answer:** No.

**Q13. For complex rehab wheelchairs is documentation of continued medical necessity required? Such as someone who is a quad, and has been for 10 years, do suppliers need the patient to go to their physician to verify continued medical necessity?**

**Answer:** No. It would not be expected that the physician would continue to document the need for a PMD.

**Q14. May a physician sign the last page of a visit note and this be considered acceptable?**
Answer: Yes. If there are 4 pages of physician progress notes it is acceptable for the physician to sign the 4th page. Suppliers should be careful though because many times during an audit it is obvious there were 4 pages but only page 1-2 are submitted and not the page with the physician signature in this case. Suppliers may utilize the physician attestation if an entry is missing a physician signature.

Q15. Does CERT allow supplier created logbooks where the patient hand writes in the data and signs it?

Answer: CERT is looking for the beneficiary logs to have the patient name that the beneficiary is actually testing at the frequency ordered and patient signature to verify that the patient did in fact complete the log.

Q16. How are suppliers supposed to educate the physicians?

Answer: The medical directors have created several “Dear Physician” letters to help assist suppliers regarding the documentation required. Suppliers are also encouraged to attach the corresponding documentation checklist to the Dear Physician letters to assist in guiding the physician in providing the documentation required for the DMEPOS item(s) ordered.

Q17. What is considered stage III or IV decubitus ulcer (measurements)?

Answer: Stage III is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss which may include undermining and tunneling. Stage IV is a full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Q18. Is there a difference between documentation scanned into a document-imaging system or the hard-copy documentation as far as which would need to be kept for the 7-year period?

Answer: Suppliers are expected to maintain documentation for up to 7 years. This documentation may be electronically maintained but in some cases the original documentation may be requested in order to authenticate what was provided. In all cases of additional documentation request copies are acceptable unless originals are specifically requested by the reviewing entity.

Q19. On the slide titled "What is NOT a Medical Record" it was mentioned that addendums after the fact are not allowed. What about addendums to records made prior to delivery? For instance in a PMD exam if the MD fails to cover one of the required topics and we notice it, can the MD go back and create an addendum as long as it is prior to our dispensing the chair?

Answer: Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the
attestation process. 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 and must contain sufficient information to identify the beneficiary.

Q20. In the case of oxygen equipment, if the physician does not document the required documentation, how do you suggest it is handled? Should the patient revisit the office for the proper documentation?

Answer: It is the supplier’s responsibility, as the entity billing Medicare, to ensure that all medical necessity requirements have been met. Once a supplier determines that they have been paid incorrectly, an overpayment refund is in order. Continued billing for oxygen, knowing that required coverage criteria are not met would be a false claim.

Q21. Does a physician’s attestation statement verify authenticity of a physician’s signature or must the physician go back to the medical record sign and date with current date and if there is confusion as to reading of a signature, then an attestation would be filled out?

Answer: If the signature is missing from the medical records, the physician/practitioner may provide an attestation to verify the entry. Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. 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 and must contain sufficient information to identify the beneficiary.

Q22. Why are suppliers held responsible for physician's illegible medical records?

Answer: Suppliers are the entity billing Medicare and receiving payment for the item(s); therefore, it is the supplier’s responsibility to ensure that the item(s) billed are reasonable and necessary.

Q23. If a physician indicates the patient is non-compliant in monitoring blood sugar or taking insulin, would that patient still qualify for therapeutic shoes & inserts?

Answer: The local medical policy and Medicare Benefit Policy manual, chapter 15, *Therapeutic Shoes for Individuals with Diabetes*, states that the need for diabetic shoes must be certified by a physician who is a doctor of medicine or a doctor of osteopathy and who is responsible for diagnosing and treating the patient’s diabetic systemic condition through a comprehensive plan of care. This managing physician must:

- Document in the patient’s medical record that the patient has diabetes;
- Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
- Document in the patient’s record that the patient has one or more of the following conditions:
  - Peripheral neuropathy with evidence of callus formation;
  - History of pre-ulcerative calluses;
o History of previous ulceration;
o Foot deformity;
o Previous amputation of the foot or part of the foot; or Poor circulation.
If the patient fails to meet any portion of this criterion, the shoes, inserts and/or modifications will be denied as noncovered.

Q24. What are suppliers to tell physicians who call and request a form for them to fill out for a power mobility face-to-face evaluation?

Answer: Suppliers are encouraged to work with their referring physicians and ensure they are familiar with the medical policies. Suppliers should utilize the “Dear Physician” letters created by the DME MAC medical directors and corresponding documentation checklist to help assist with guiding the physicians in documenting the need for the power mobility device.

Q25. For diabetic shoes, what is considered a comprehensive care of plan for diabetes?

Answer: A comprehensive plan of care for diabetes would be the direction and plan the treating physician has determined in order to address the patient’s condition. This could include but is not limited to: history, prognosis, medications, treatments, and directives to be used to help stabilize and maintain the patient’s health.

Q26. For enteral nutrition specifically for diabetics, when asking for specific documentation regarding the trial on another formula what exactly is Medicare looking for?

Answer: There are no specific detailed documentation requirements in this situation but the medical record should provide an overall picture of that particular patient’s condition, previous treatments, prognosis, and need for the item ordered.

Q27. How can suppliers obtain an attestation form/signature attestation form?

Answer: Should a physician/practitioner choose to submit an attestation statement, they may choose to use the following statement:

“I ____________________ [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.”

Q28. Would a form created by the physician that includes all the required details per the medical policy for diabetic supplies be sufficient for medical record documentation?
Answer: A form can be used to provide medical record documentation but in most cases the documentation is limited and does not provide enough information to substantiate the need for the item or that particular patient’s medical condition necessitating the need for the item ordered.

Q29. If a beneficiary resides in a skilled nursing facility (SNF) and daily nurse notes or progress notes/dietary records are used with the nurse signature only would this be sufficient for medical records or does the ordering physician need to sign off?

Answer: Please see the response to question #3 in medical record section.

Q30. Can an Advance Beneficiary Notice of Noncoverage (ABN) be provided if the beneficiary’s physician is not providing proper documentation to support medical necessity?

Answer: If the supplier exhaust every avenue to obtain medical documentation to support the need for the DMEPOS items ordered, and is unsuccessful, it is acceptable for the supplier to issue an ABN. The ABN must document the specific reason for why the patient does not meet medical necessity.

Q31. Who can perform a swallowing evaluation for enteral nutrition a primary care physician (PCP) or speech therapist?

Answer: Either one; however, speech-language pathologists who specialize in swallowing disorders are often consulted to perform a swallowing evaluation.

Q32. What is the allowed frequency for HCPCS L0456 when replacing the item for wear and tear, and what are the documentation requirements?

Answer: The reasonable useful lifetime (RUL) for a Thoracic-lumbar-sacral orthoses, L0456 is 5 years. Therefore Medicare would not cover replacement prior to this timeframe due to wear and tear. Replacement for a L0456 prior to the 5 year RUL would only be covered if the item was lost, stolen, or irreparably damaged but does not include normal wear and tear.

Q33. Is the continued medical need documentation required if CERT pulls a claim for review?

Answer: CERT would look for continued need documentation for items that are provided on a reoccurring periodic basis.

Q34. When proving continued use of oxygen for the contemporaneous notes, is it sufficient if the chart notes simply list the oxygen use in the medication portion of the chart when patient is in for another routine visit?

Answer: There should be some sort of documentation in the patient’s medical records indicating the physician’s over site for continued use and need of the oxygen.
Q35. If the certifying physician does not indicate the qualifying foot condition for diabetic shoes but indicates they referred the beneficiary to a podiatrist is this valid medical record documentation to support coverage criteria has been met?

**Answer:** The certifying physician may choose to refer the beneficiary to a podiatrist regarding the foot condition but in order for this documentation to be considered as part of the certifying physicians medical records he/she must sign off and date concurrence prior to or the same day as completing the Statement of Certifying Physician.

Q36. It was indicated that supplier created forms (even completed by a physician and included in the chart) are not considered as part of the comprehensive medical record. So if a physician signs and dates a written confirmation of a verbal order is it not acceptable if they are signing a form (of any kind) generated by the supplier?

**Answer:** If a physician completes a supplier created form, these forms are not considered part of the beneficiary’s comprehensive medical records even if the physician signs, dates, and includes the form within their charts. During pre or post payment audits, supplier created forms will not stand alone in order to support medical necessity for the ordered DMEPOS item.

Q37. Is there any way for suppliers to obtain more specific information regarding their CERT denials?

**Answer:** Suppliers should contact the appropriate Provider Contact Center in order to obtain additional information on their denials. Suppliers will need to have the following information prior to calling:
- CERT identification (CID) number assigned to the claim
- The beneficiary’s name
- Health Insurance Claim Number (HICN)
- Provider Transaction Number (PTAN)
- National Provider Identifier (NPI)
- Last five digits of the supplier’s tax identification number

Suppliers should refer to the DME MACs Web sites to determine the appropriate Provider Contact Center:
- Jurisdiction A, NHIC, Corp – http://www.medicarenhic.com
- Jurisdiction D, Noridian Administrative Services, LLC – http://www.noridianmedicare.com

Q38. How are suppliers to handle when a physician refuses to correct medical notes that are illegible or incomplete?

**Answer:** If a supplier is unable to obtain supporting legible medical record documentation from the physician prior to dispensing the item(s), then the supplier has a business decision to make. If from the documentation received indicates the patient does not meet coverage criteria as outlined
in the policy, suppliers must make a business decision whether or not to supply the product. If suppliers choose to supply the product to the beneficiary, suppliers must make the decision whether to provide a properly executed Advance Beneficiary Notice of Noncoverage (ABN) with details for the specific reason the beneficiary does not meet coverage criteria or provide for the items for free.

Q39. How often do suppliers need to get diabetic logs for patients over-utilizing?

Answer: Per the LCD, if the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

Q40. For an oxygen claim if denied during an audit as not medically necessary because information was not sent what can suppliers do to start getting claims paid again?

Answer: The Medicare program offers suppliers the right to appeal audit findings that they are not in agreement with. In fact, CMS encourages suppliers to appeal audit findings when documentation is available and supports the items or services provided as the purpose of the appeals process is to ensure the correct adjudication of claims.

Suppliers should refer to the DME MACs Web sites to determine the appropriate forms, addresses, and or faxes to utilize when submitting their appeals request:
Jurisdiction A, NHIC, Corp – http://www.medicarenhic.com
Jurisdiction C, CGS Administrators, LLC – http://www.cgsadmin.com
Jurisdiction D, Noridian Administrative Services, LLC – http://www.noridianmedicare.com

Q41. What type of documentation is required for HCPCS A6261 and A6262 (unspecified wound filler) when medical policy does not state what is specifically required as far as amount of exudate, stage of wound or depth of wound?

Answer: Surgical dressings are covered when either they are required for the treatment of a wound caused by, or treated by, a surgical procedure; or they are required after debridement of a wound. Furthermore, use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented. It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate). The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change and the recent use of dressings, and surgical dressings must be tailored to the specific needs of the patient.

Please note there are unique codes for other wound fillers, e.g. A6024 (collagen, A6199), A6215 (foam), etc.
Not Otherwise Classified (NOC) coded wound fillers are covered under the same rules as specifically-coded wound fillers, i.e., when a qualifying wound is large (deep) enough to require a filler to close the space and the material of the filler is appropriate to the wound type (e.g., hydrogel on a dry wound or collagen on an exudative wound). The filler chosen must be compatible with the primary dressing as well.

Q42. Do the referring doctor’s medical records need to have the functional level of the patient for prosthesis? The policy states "and or" the referring doctor - prosthetist.

Answer: A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient’s potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician. This expectation of functional ability information must be clearly documented and retained in the prosthetist’s records. There must be information in the treating physician’s records about the patient’s history and current condition which supports the designation of the functional level by the prosthetist.

Q43. It was stated on the call that CERT is looking for the beneficiary signature on test logs?

Answer: There is no requirement for the beneficiary to sign and date their testing logs.

Q44. For oxygen recertification the patient needs to have a documented office visit with the physician who is going to sign the CMN. What exactly should the progress notes completed during this visit include?

Answer: The progress notes should include, at minimum, compliance with current oxygen treatment, continued need for oxygen, any new issues with usage of oxygen, etc.

Q45. If a physician determines that a piece of equipment is needed for their patient while the patient is in their office and they send the patient to our office with a prescription in hand for that equipment, generally speaking, the SOAP notes or chart notes VERY rarely ever have the supporting documentation that is required by Medicare. Is it okay for the physician to type or write up a "letter of medical necessity" on their letterhead with all supporting documentation of medical necessity that pertains to that patient for that piece of equipment, to go along with the chart notes from that day? Will this suffice to prove medical necessity as long as it is obtained prior to dispensing the product?

Answer: No. 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 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 including, but not limited to, 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. However, neither a physician’s order, nor a supplier-prepared statement, nor a physician attestation by itself
provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There must be clinical information in the patient’s medical record which supports the medical necessity for the item and substantiates the information on a supplier-prepared statement or physician attestation (if applicable).

Q46. What are suppliers to do when an amputee has a broken or deteriorated component and needs to be seen immediately to avoid further damage to prosthesis or residual limb, or potential injury?

Answer: Repairs to prosthesis are covered when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payments can be made for the amount of the excess. Maintenance which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist is covered as a repair.

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

- A change in the physiological condition of the patient; or
- Irreparable wear of the device or a part of the device; or
- The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician’s order when it is determined that the prosthesis as originally ordered still fills the patient’s medical needs.

Q47. Is a revised DIF required for enteral nutrition?

Answer: A revised DIF for enteral nutrients is required when:

- The number of calories per day is changed, or
- The number of days per week administered is changed, or
- The method of administration (syringe, gravity, pump) changes, or
- The route of administration is changed from tube feedings to oral feedings (if billing for denial).

Q48. Can handwritten oxygen saturations from the facility, prior to discharge, be acceptable if written by a registered nurse (RN) or Physician?

Answer: Testing done in hospital needs to be recorded and reported in the standard way that the particular hospital records and reports lab test results. That record of the test must then be made available upon request. Alternatively physicians may make note of the test result after reviewing the report. The progress not with the included test result would also be an acceptable source.
Q49. Medicare policy states you only need a revised CMN if the liter flow changes to over 4lpm not if it changes from 2-3lpm, is this correct?

**Answer:** A revised CMN is required:
- When the prescribed maximum flow rate changes from one of the following categories to another:
  - less than 1 LPM,
  - 1–4 LPM,
  - greater than 4 LPM
- When the length of need expires – if the physician specified less than lifetime length of need on the most recent CMN.
- When a portable oxygen system is added subsequent to Initial Certification of a stationary system.
- When a stationary system is added subsequent to Initial Certification of a portable system
- When there is a new treating physician but the oxygen order is the same.
- If there is a new supplier and that supplier does not have the prior CMN.

Q50. Are physicians being trained on the continued need documentation for medical necessity of equipment and legible signatures?

**Answer:** CMS and contractors have provided information to the Medicare physician and hospital community in regards to the requirements for the supplier community to provide continued services for Medicare beneficiaries.

Q51. We have a CMN from the hospitalist for oxygen. Patient is discharged from the hospital. Patient follows up with primary care physician. No change in liter flow. No revised CMN necessary, correct?

**Answer:** A revised CMN would be required since there is a change in the treating physician.

Q52. We provide custom wheelchair seating, what information is required in the doctor’s notes?

**Answer:** Documentation should contain at minimum:
- Patient meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion outlined in the LCD;
- Patient meets all of the criteria for a prefabricated positioning back cushion outline in the LCD;
- There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the patient’s seating and positioning needs. The PT or OT may have no financial relationship with the supplier.
Q53. If doctor “A” performs a face-to-face assessment and orders a PT/OT evaluation and the PT/OT evaluation is sent back to doctor “A” for concurrence but doctor “A” is on vacation for two weeks, must we wait for doctor “A” to return, or may another physician within the practice sign for the prescribing physician?

Answer: Dr. B merely needs to be filling in for Dr. A and it needs to be clear that his is what is occurring.

Q54. Is medical necessity documentation required for canes?

Answer: Please refer to the Canes and Crutches medical policy and policy article for coverage criteria requirements.

Q55. Do medical records have to document specific need for anti-tippers, general back/seat cushions or is medical necessity justified by diagnosis and prognosis and can the suppliers detailed written order justifying the accessories?

Answer: The medical necessity for all options and accessories must be documented in the patient’s medical record and be available on request. This documentation might include information on why the patient needs the item, the patient’s diagnosis, the patient’s abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

Q56. Is it acceptable if a supplier has an order from one physician but medical records from another physician if they work in the same hospital?

Answer: Yes it is acceptable. The patient’s medical record is not limited to the physician’s office records, and may include hospital, nursing home, or home health agency records. Patient medical records also include medical documentation from other professionals including, nurses, and physical or occupational therapists as long as those individuals have no financial relationship with the supplier.

Q57. Is it acceptable for a doctor to write that he concurs with the OT/PT evaluation on the bottom of their evaluation?

Answer: There is no requirement for the physician to concur with the OT/PT evaluation unless a portion of the exam is being considered as a part of the face-to-face examination.

Q58. If after Physician "A" does the face to face and the beneficiary changes physicians and Physician "B" is not within the same practice may Physician "B" still sign the PT/OT evaluation? Or does the beneficiary need to start over with the new physician?
**Answer:** “No. The LCD/NCD/statute requires that the physician who performs the face-to-face (both components) must be the one to write the seven-element order. A change in treating physician would require a new visit to request a PMD, and a new evaluation by the new physician.

**Q59. Can suppliers keep a copy of the signed attestation statements on file in order to submit at any time or a later date?**

**Answer:** Suppliers are encouraged to keep all records associated with the item that they have billed for. The approved physician attestation statements may be used for a medical entry that was not signed by the physician or illegible signature. One attestation statement is not valid for the entire medical record. It is only valid for the date of service attested to.

**Q60. Are physician’s notified of these webinars and how is it expected for suppliers to education medical professionals on how to document in their charts?**

**Answer:** The DME MACs are funded to provide education to DMEPOS suppliers. However, the DME MACs do try and assist in educating ordering physicians. We have developed “Dear Physician” letters and “Documentation Checklists” to assist suppliers in obtaining the required documentation. Each jurisdiction has their own listserv articles to help keep supplier up to date with Medicare. These publications are open to anyone, including physician’s and are a good way to keep them abreast of any educational offerings.

**Q61. Regarding fluctuating blood sugars, is there a definition used by Medicare?**

**Answer:** No. The patient’s medical records should document whether the ordering physician believes the patient has fluctuating blood glucose levels including any signs and symptoms associated with fluctuating blood sugar levels.

**Q62. What are some specific examples of patient conditions or documentation that would support special enteral nutrients?**

**Answer:** The documentation should provide evidence for the need of the specialty nutrient over one of the basic nutrients. This documentation may include but is not limited to, physician progress notes, labs, hospital records, and the products packaging. The diagnosis alone does not support the need for a specialty nutrient. For example, a diabetic patient does not necessarily need to be placed on glucerna. The documentation should be tailored to each patient and their current condition.

**Q63. What time frame is acceptable regarding testing logs for a patient over-utilizing glucose supplies?**

**Answer:** The log provided should be within an approximate time frame to the claim in question.
Q64. Is medical necessity documentation required for diabetic supplies?

**Answer:** Yes. The Glucose Monitors Local Coverage Determination outlines the documentation requirements for diabetic testing supplies.

Q65. Can you provide an example of medical notes for an over-utilization diabetic patient that you find acceptable to justify the testing frequency?

**Answer:** The documentation should provide evidence for the need to test at a higher frequency. This documentation may include but is not limited to, physician progress notes, labs, and hospital records. The documentation should be tailored to each patient and their current condition.

Q66. Relevant medical records verifying the beneficiary has severe lung disease/hypoxia-related symptoms that might be expected to improve with oxygen therapy and that alternative treatment measures have been tried or considered and deemed clinically ineffective. Please give detail as to what alternative treatment measures Medicare is referring to?

**Answer:** Many disease conditions have standard treatment regimens associated with them. This criterion, together with the requirement that testing be done while the patient is in their chronic, stable state means that the usual treatment modalities need to be optimized before oxygen becomes eligible for reimbursement.

Q67. The Glucose Monitor LCD indicates that a supplier is required to get progress notes or a diabetic testing log every 6 months for beneficiary orders that exceed utilization guidelines. We have heard that documentation to validate these requirements must be relative to the DOS and needs to be dated within 3 months of the DOS to be valid. Is this the case?

**Answer:** The progress notes or testing log should be within six months prior to the date of service on the claim.

Q68. If a supplier creates an intake form that contains the beneficiary’s information, the ordering physician information and a listing of equipment/supplies that the ordering physician can check for the medical need of the beneficiary, is this acceptable?

**Answer:** Many suppliers create “intake forms” to record beneficiary eligibility information and other information necessary for the supplier. Documentation regarding the medical necessity for the item being billed will need to come from the patient’s comprehensive medical record per the applicable medical policy.

Q69. What recourse do suppliers have when ordering physicians refer their beneficiaries to suppliers that do not require documentation up front?
Answer: Beneficiaries have the right to choose where and from whom they receive DMEPOS items. Physicians can provide the names of DMEPOS suppliers in the area but ultimately it is up to the beneficiary to make the choice.

Q70. Do repairs require physician medical records?

Answer: Documentation for a repair does not have to be documented in the medical record. The item being repaired and the repair itself do need to be considered medically necessary per Medicare guidelines. The supplier should have complete and detailed records about the repair.

Q71. If a patient has an HMO and qualifies for Medicare is a new CMN required?

Answer: It depends on whether the item was initially started in FFS or was started in the HMO. For items started in the HMO, all FFS requirement for a new initial item must be met unless otherwise stated in the medical policy.

Q72. If a consumer receives a wheelchair from one physician and 3 years later requires repairs to this wheelchair and is no longer seeing the physician that originally ordered the wheelchair, do suppliers use the original physician as the physician for the repairs or is the physician who is currently following the consumer’s care eligible to document the need for the repair?

Answer: A new CMN and or physician order is not needed for repairs unless specifically indicated in the LCD. However, if you are looking for documentation of continued use and need you should contact the physician that is currently treating the patient.

Q73. Physicians do not typically understand function levels for amputees regarding prosthetic devices. We have been trying to educate our physicians on function levels and how to document them, but we don’t usually get detailed information from the physician regarding function level. What should suppliers do in this case?

Answer: Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician. The records must document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. The expectation of functional ability information must be clearly documented and retained in the prosthetist’s records. There must be information about the patient's history and current condition which supports the designation of the functional level by the prosthetist.

Q74. As a pedorthist, can a physician sign off on a foot exam and the patient needing diabetic shoes and inserts that the pedorthists completes?

Answer: No. Pedorthists are not recognized as medical provider for Medicare documentation purposes. A pedorthic exam would not be an acceptable substitute for a medical exam, even if co-signed by a physician (PIM 5.7 exclusion of supplier records as a substitute for medical records.
Q75. If a supplier has several locations with different NPI numbers but is the same company and a patient goes from one location to another, is new documentation required?

Answer: Suppliers are identified to the DME MAC by the NPI/PTAN combination. If a claim is received and processed for NPI 1234567890, the documentation must correlate to the billing NPI of 1234567890. If a different NPI of 0987654321 is billed, the documentation must correlate to the billing NPI of 0987654321.

Per Medicare requirements, if there is a change in the supplier or treating physician, new documentation is required. Examples of new documentation include, but not limited to, detailed written order, Certificate of Medical Necessity, DME Information Form, and Proof of Delivery.

Q76. Should a signature attestation be routinely sent with medical records if legibility of the signature is in question?

Answer: Yes.

Q77. A lot of our enteral patients have been on service for a number of years. As an example a patient has been on service for 10+ years. At that time CMNs were used in lieu of medical records. CMNs are no longer valid in an audit so we have to go to the physician and/or hospital for medical records. Old medical records may not be available showing that a formula other than Glucerna was tried first. How does that affect a CERT audit? I have a patient who has been on enteral for approximately 14 years. The previous physician is now deceased and saw the patient in the hospital. We have the old CMN but are unable to obtain medical records indicating the patient was tried on a formula other than Glucerna first.

Answer: The CMS Internet-Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.7 (251 KB) states:

“However, neither a physician’s order nor a Certificate of Medical Necessity (CMN) nor a Durable Medical Equipment Regional Carrier Information Form (DIF) nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).” CMNs and DIFs have never been sufficient to support medical necessity. There has always been an expectation that medical records would support the responses to questions on the CMN or DIF.

Q78. On the slide titled "What is NOT a Medical Record" it was mentioned that addendums and after-the-fact letters are not acceptable. What about addendums to records made prior to delivery?
**Answer:** Physicians/practitioners should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process), but instead may make use of the attestation process. 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 and must contain sufficient information to identify the beneficiary.

**Q79. If the patient owns their DME equipment and the doctor that they currently see, didn’t provide the equipment and it needs to be repaired, will the new doctor need to provide updated medical necessity for continued use?**

**Answer:** Medicare does provide reimbursement for repairs made to medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable. It is expected that the beneficiary has visited his/her treating physician with 1-year of the date of service under review, and that documentation within the beneficiary’s medical record (i.e., notes within the current treating physician’s records) reflects the ongoing need and continued use of the item.

**Q80. If we call the IVR to check on an E0143 HCPCS code, would that be same or similar to a K0001 or/and a manual wheelchair (MWC)?**

**Answer:** If you use the same/similar option on the IVR to check for HCPCS code E0143, the system will not check to see if the beneficiary owns/rents a manual wheelchair (K0001). In order to determine if the beneficiary already owns or rents a K0001, you must enter that code as well.

**Q81. What are the credentials of the persons reviewing the claims for medical necessity? Is there someone familiar with Orthotics and Prosthetics reviewing for claims of this nature?**

**Answer:** The medical professional staff at AdvanceMed, the CERT review contractor consists of board certified physicians, nurses, physical therapists, occupational therapists, speech-language therapists, and other allied health professionals.

**Q82. When follow-up visit documentation is requested but it is not within the timeframe for the patient to see the physician, will we be held accountable for providing said documentation when it’s due?**

**Answer:** Yes. It is the supplier’s responsibility to provide all requested documentation to support the medical necessity of the item for which they are billing. All requested documentation must be provided so the reviewer can make an accurate determination. If the supplier does not provide all requested documentation, the reviewer will make a determination based upon the documentation the supplier provided.

**Q83. What about when new technology comes available that could significantly benefit a patient and the reasonable useful lifetime (RUL) has not passed? Is it possible to get a new suspension method socket covered? What documentation is required?**
Answer: Medicare will provide reimbursement for replacement of a prosthetic when the item has reached its RUL, has sustained irreparable damage, or when the physician has ordered a replacement due to a medically necessary reason (i.e., it is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.)

Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, and socket) must be supported by a new physician’s order. The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request.

Q84. If during an audit it is discovered that the documentation is inadequate and a denial is given, are suppliers able to file a redetermination acknowledging that we are unable to obtain records from the physician?

Answer: Yes. Suppliers may file a request for redetermination acknowledging that they are unable to obtain records from the physician; however, unless additional documentation is provided that supports medical necessity, the CERT contractor’s decision may be upheld.

Q85. If during an audit the documentation is inadequate and a denial is given, can suppliers contact the ordering physician for a pick-up order since the ordering physician will not provide additional documentation?

Answer: If Medicare denies payment for a DMEPOS item and the beneficiary is relieved of liability for payment for that rental item (supplier is held liable), this effectively cancels the contract for the sale or rental of the item and, if the item is re-sellable or re-rentable, the supplier may repossess that item (unless state law prevents the supplier from doing so) for resale or re-rental if the supplier refunds amounts collected. In regards to consumable items that may not be fit for resale, suppliers are strongly discouraged from recovery of those.

The supplier may enter into a new sale or rental regardless of whether or not the supplier physically repossesses the re-sellable or re-rentable item, as long as the beneficiary has been informed of their liability. The supplier can establish the beneficiary’s liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary that Medicare will not pay for the item and obtaining the beneficiary’s signed agreement to pay for the item. The resale or re-rental does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Q86. Are testing logs required for diabetic beneficiaries that are obtaining therapeutic shoes?

Answer: Testing logs are not required documentation to support a claim for therapeutic shoes. Diabetic shoes and inserts are eligible for coverage if the patient has documented diabetes
mellitus and meet one or more of the conditions as outlined in the local coverage determination (LCD) and policy article documented in the medical records by the certifying physician. Documentation requirements for Diabetic Shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article located on the DME MACs Web sites.

**Q87. If a supplier cannot determine medical necessity of the item, should the item be dispensed and billed to Medicare?**

**Answer:** Suppliers must refer to the Local Coverage Determination and related Policy Article to determine whether an item meets Medicare coverage guidelines and medical necessity criteria. The medical policies are located on the DME MACs Web sites.

The DME MACs suggest that suppliers obtain supporting documentation up-front in order to determine if the documentation supports medical necessity criteria have been met. If documentation does not support medical necessity, the supplier may execute an Advance Beneficiary Notice of Noncoverage, citing the specific reason Medicare does not consider the item medically necessary for the beneficiary. If the beneficiary does not accept financial responsibility for the item by signing the ABN, the supplier should consider not providing the item. If the supplier provides an item to the beneficiary that is not medically necessary and does not obtain a signed ABN, the supplier must append modifier GZ to the claim line. Use of this modifier will result in a denial holding the supplier liable.

**Q88. If a supplier has a letter of medical necessity from the physician documenting the need for blood glucose testing supplies, is a 30-day blood glucose testing log also required?**

**Answer:** Attestation letters of medical necessity are not considered part of the medical record and are not sufficient to support the medical necessity of an item, even though they may be signed by the physician.

**Q89. Do signed and dated statement of medical necessity forms serve as medical record documentation if they are obtained prior to claim submission?**

**Answer:** No. The documentation should be in the physician’s normal narrative format and be signed and dated by the treating physician. Addendums and after-the-fact letters, even though they may be signed by the physician, are not considered part of the medical record and are not sufficient to support the medical necessity of an item. As it is stated in the PIM 100-8 Chapter 5 Section 5.7 "However, neither a physician’s order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."
Q90. Does Medicare only cover accessories if they are paid for the base equipment (i.e., wheelchair accessories, hospital bed accessories, etc.)? If the answer is yes, where can I find that information in writing?

**Answer:** Medicare will cover supplies but not necessarily accessories for beneficiary-owned equipment that was not paid for by Medicare fee-for-service (FFS)—i.e., only equipment that was paid by other insurance or by the beneficiary. For supplies and accessories used with that equipment, all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the 2400.NTE segment for electronic claims:

- HCPCS code of base equipment
- A notation that this equipment is beneficiary-owned
- Date the patient obtained the equipment

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be rejected with ANSI code PR-16. When PR-16 is received for this reason, the supplier must resubmit the claim with the correct information in the NTE segment.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the contractor or a redetermination request, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable local coverage determination(s) and related policy article(s) for information on the relevant coverage, documentation and coding requirements.

Q91. Why is the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier responsible for determining what is reasonable and necessary for the beneficiary? For example, if the treating physician prescribes a specific surgical dressing to treat a beneficiary’s wound, how should the supplier determine if it is medically necessary even though it was ordered?

**Answer:** Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider.” It is expected that the patient's medical records will reflect the need for the care provided. The patient’s medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request. It is the responsibility of the entity billing Medicare to ensure the items they provide and for which they are seeking Medicare reimbursement, meet medical necessity criteria indicated out the in the Local Coverage Determination and Policy Article. Therefore, suppliers must refer to the LCD and Policy Article for the items they provide. The indications of coverage and medical necessity criteria, as well as documentation requirements are spelled out in the medical policies which are available on the DME MACs Web sites.
Q92. If a new beneficiary comes in with a prescription for diabetic testing supplies and the treating physician has indicated the beneficiary tests more often than allowed by medical policy (over utilization), do suppliers obtain medical records and beneficiary testing logs to justify the need for overutilization for that claim?

**Answer:** Yes. The documentation that should be provided if requested in an audit for a diabetic beneficiary testing above the typical allowed amount would include; written order, physician progress notes regarding the patient’s condition and need for testing above the allowed amount, patient’s testing log showing they are in fact testing the prescribed amount of times, request for refill, and proof of delivery.

Q93. What documentation should be in the medical records for mobility assistive equipment (MAE)? Do the mobility related activities of daily living (MRADLs) that are affected need to be specific?

**Answer:** The medical record must contain information showing that the applicable policy coverage criteria are met. The Indications and Limitations of Coverage and/or Medical Necessity differ according to the MAE; therefore, for medical necessity criteria and documentation requirements, suppliers should refer to the medical policy specifically for the item they are providing.

Documentation of MRADLs should be objective and as specific as possible.

Q94. As an Occupational Therapy practice who provides splints to beneficiaries, do the requirements apply to this type of practice?

**Answer:** All Medicare providers and suppliers are subject to CERT audits and must be prepared to provide supporting documentation upon request.

Q95. If the item that is being provided is customized, does the person doing the measuring have to be employed by the DMEPOS supplier or can someone at the hospital where the beneficiary is being discharged from, actually take the measurements?

**Answer:** There is no Medicare policy requirement that the person completing the customized measurements be employed by the supplier.

Q96. What information can a supplier provide to instruct the ordering physician on how to complete a CMN?

**Answer:** Instructions regarding completion of the CMN are indicated on the back of the CMN. Suppliers are prohibited from completing Section B on the CMS forms 484, 846, 847, 848, and 849. Section B must be completed by the physician, the physician’s employee, or another clinician involved in the care of the patient (e.g., nurse, physical or occupational therapist, etc.) as long as
that person is not the supplier. Suppliers may assist the physician by answering the physician’s questions or providing instructions, but may in no way lead the physician to provide a specific answer.

Q97. What documentation is required in order to dispense therapeutic shoes for a person with diabetes? What constitutes a physical examination of the patient’s feet before and at the time of dispensing the shoes?

Answer: Suppliers of diabetic shoes are not required to obtain supporting documentation at the time the service(s) is provided. Per the Therapeutic shoes for Persons with Diabetes medical policy, suppliers must add a KX modifier to codes for shoes, inserts, and modification only if criteria 1-5 in the Non-Medical Necessity Coverage and Payment Rules section of the related Policy Article have been met. If the documentation requirements have not been met, suppliers must append the GY modifier. In order to determine which modifier is required for claim submission, the supplier must determine whether the criteria have been met; thus, the supplier would have to obtain documentation from the treating physician prior to claim submission. Documentation requirements for diabetic shoes are available in the Therapeutic Shoes for Diabetics LCD (L11525) and Policy Article located on the DME MACs Web sites.

Per the Therapeutic shoes for Persons with Diabetes Policy Article, prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the patient. Additionally, at the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient.

The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the patient’s feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient’s feet.
3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient’s fee that will be used in creating positive models of the feet.

The in-person evaluation of the patient by the supplier at the time of delivery must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

Q98. If suppliers are providing an amount of blood glucose testing supplies above what is normally allowed by Medicare and the beneficiary can only provide a two week testing log, would a statement from the treating physician be sufficient to support medical necessity?

Answer: Attestation letters or after-the-fact letters signed by the physician are not considered part of the beneficiary’s medical record. The patient’s medical records must reflect the need for
the item being ordered. The documentation should be in the physician’s normal narrative format and be signed and dated by the treating physician.

**Request for Refill:**

Q1. "Quantity of each item that the beneficiary still has remaining," would this requirement pertain more to enteral and diabetic supplies, rather than cpap/bipap or nebulizer supplies?

**Answer:** The refill requirements apply to all DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) items that are refilled on a recurring basis.

Q2. When you are asking for a quantity of all items the patient still has remaining - for items that are billed with a "kit code" such as enteral feeding kits (B4034, B4035, B4036), do we need to know the quantity of each and every item - such as gauze, tape, needles, etc. - when these items are not billed separately? Is it necessary to list them out on the refill request OR can we ask "how many kits do you have left?"

**Answer:** Documentation of approximately how many kits the beneficiary has on hand will allow the supplier to calculate when they may ship new supplies no sooner than 10 days prior to the previous kit’s end of usage. The use of individual items within a kit may differ from patient to patient and day to day. Individual items do not need to be counted.

Q3. Is it possible that a supplier’s billing department vs. the shipping department vs. the customer service department is off by one day in calling for refill, billing, or shipping or is that not allowed? Can you appreciate the fact that if the billing department billed for the claim today, but the shipping department was backed up so it didn’t go out until the next day, our shipping and billing dates would be off by one day?

**Answer:** Per the CMS Internet Only Manual 100-08 Chapter 4 Section 4.26.1, if a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Q4. In regards to the Diabetic Supplies LCD, when refilling a 90 day supply for a beneficiary that exceeds the utilization guidelines, after the supplier receives the progress notes to show the need for the additional materials when supplying the original order, would it be appropriate for the supplier to only get a Diabetic Testing Log showing the testing frequency from the beneficiary every 6 months in order to supply the continued refills of the ordered supplies?

**Answer:** The refill request must occur and be documented before shipment. The refill record must include:

- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
• Quantity of each item that the beneficiary still has remaining

Q5. How do you recommend we document the quantity remaining for cpap supplies, such as a mask refill? The beneficiary might have the one they are currently using, but not an extra one.

Answer: In the case of the mask, it may not be the quantity is exhausted but it is reasonable and necessary to replace the supply. Replacement of CPAP supplies is not automatic. Items should only be replaced when the current one is no longer serviceable. Documentation of contacting the beneficiary prior to dispensing refills ensures the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. The supplier may document the date and quantity of the previous supply dispensed.

Q6. Regarding the request for refill, if the beneficiary resides in a SNF and is not able to determine needs, can a call to the nursing facility nurse be sufficient for determining refill requirements? Can our company representative sign the request for refill for documentation?

Answer: Contact may be made to the beneficiary or a designee. Documentation may take the form of a written request received from the beneficiary or designee or a supplier written record of a phone conversation/contact between the supplier and beneficiary or designee.

Q7. For a CPAP supply, the beneficiary has the supply they are currently using, but will discard when they return home with the replacement supply. What quantity on hand is documented as what the beneficiary still has?

Answer: Please see response to question #5 in request for refill section.

Q8. Is a DME supplier of diabetic testing supplies required to get the patient’s prior three months of logs before dispensing the next three months of supplies?

Answer: If refills of quantities of supplies exceed the utilization guidelines, there must be documentation in the physician’s records (specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary’s log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is not exceeding the utilization guidelines, the supplier must document how many days supplies the beneficiary has remaining to determine the delivery of the refills no sooner than 10 days prior to the expected end of usage of the previously dispensed supplies.

Q9. Should we automatically request diabetic testing logs from patients prior to dispensing refills?

Answer: Only if refills of quantities of supplies exceed the utilization guidelines, there must be documentation in the physician’s records (specific narrative statement that adequately
documents the frequency at which the patient is actually testing or a copy of the beneficiary’s log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed.

Q10. When ordering refills, example 2 asks how many supplies does the patient have left? Is this question concerning how many the patient currently has left?

Answer: Correct, in the example provided, the question was asking the amount of supplies the beneficiary has remaining. This could be how many days of supplies the beneficiary has on hand from the previous supplies dispensed.

Q11. If a beneficiary tells you they have 15 days of supplies left, do you need to re-contact them since it is greater than 14 days?

Answer: You do not need to re-contact the beneficiary. The supplier would document how many days of supplies the beneficiary has left and then deliver the next amount of supplies no sooner than 10 days before the end of usage on the supplies.

Q12. If a patient comes into the store for a refill of diabetic supplies, are we required to ask what is on hand and the frequency of utilization?

Answer: For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

Q13. I’m trying to get a complete picture of items that need to be addressed when contacting a patient for a reorder of diabetes testing supplies. The LCD list more items than were addressed on the slides in his webinar.

Answer: For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Information documenting that the beneficiary’s remaining supply is approaching exhaustion by the expected delivery date.

Q14. Question regarding refill documentation for enteral nutrition therapy. I would like to clarify the statement that it would be acceptable to state “xx days’ supply left” for this type of
therapy - or do we need to list out the individual items such as Enteral Formula, Enteral syringe, Enteral bags with the quantity remaining for all the specific items.

Answer: The supplier must document the amount of days of formula and the amount of days of supply kits remaining.

Q15. For request for refills, we must document the quantity of supplies remaining. How exactly should this be stated? Are we required to say the exact number of units that the beneficiary has remaining, or can we state a more general reference (e.g. "beneficiary has two weeks' worth of supplies remaining")?

Answer: Suppliers should state how many days of supplies the beneficiary has remaining to ensure that new supplies are shipped no sooner than 10 days prior to the end of usage of the previously dispensed supplies.

Q16. In regards to urological supply request for refill, it stated we can dispense up to 3 month supply at a time?

Answer: For urological supplies, suppliers may dispense no more than a three-month supply at any one time.

Q17. Page 50 of the presentation discusses refills. On our initial order for prosthetic filling socks we state that they need to be replaced every 5-6 months. If the patient contacts us 7 months later and says all their socks are worn out -- does this 14 day "refill" rule apply to prosthetic socks? If so, does it mean that I cannot deliver the needed socks until 14 days after they contacted us saying they needed them?

Answer: If the beneficiary is contacting the supplier for refills, this indicates the supplies are at or near the end of usage and refills may be dispensed.

Q18. Can we dispense a 3 month supply of catheters as long as the amount does not exceed quantity of 200 dispensed?

Answer: For urological supplies, suppliers may dispense no more than a three-month supply at any one time.

Q19. Does the request for refill documentation apply to beneficiaries who pick items up directly from the pharmacy?

Answer: Please see answer to question #12 in request for refill section.

Q20: What documentation is required to show the beneficiary requested a refill of positive airway pressure (PAP) supplies? Are suppliers required to document the number of supplies the beneficiary has remaining?
Answer: The refill request must occur and be documented before shipment. The refill record must include:
- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

Q21. When providing a refill for items required on a reoccurring basis suppliers cannot deliver the refill sooner than ten calendar days prior to the end of usage for the beneficiary’s current supply?

Answer: Correct.

Q22. If billing Medicare for refills, what documentation is required?

Answer: The refill request must occur and be documented before shipment. The refill record must include:
- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

Proof of Delivery:

Q1. What if the patient is unable to sign a delivery ticket- physically or in a setting such as the operating room- for an item required (brace, orthosis, etc.)?

Answer: A designee of the beneficiary may sign on their behalf. Be sure to indicate the relationship to the beneficiary on the delivery slip.

Q2. On the proof of delivery slip is a prescription RX number sufficient for the item dispensed along with the date of service and subscriber signature or must there be a detailed description of the item dispensed to be a valid proof of delivery?

Answer: No, that would not be sufficient. It must have a detailed description of the items so the beneficiary can understand what they have received.

Q3. Can we use the date on the delivery ticket as the date of service verses the shipment date?

Answer: No, it must be the shipping date for items delivered via mail order.

Q4. We have billed date of discharge and received denial still part A? Why is that?
**Q5. If a drug is delivered to a Hospital for use after discharge but the discharge is delayed one day, does this fall under the Date of Service exception?**

**Answer:** You may only deliver directly to a hospital for fitting or training purposes. However, you may deliver the drugs to the patient’s home within two days prior to discharge for their availability.

**Q6. Can we deliver a 90 supply of CPAP supplies and how do we bill the items? Do we just include a narrative note that the item is for a 3 month supply or bill monthly?**

**Answer:** Yes. It is acceptable to bill a 90 day supply of CPAP supplies. Be sure to include a note in the NTE field indicating “3 month supply” or “90 day supply”.

**Q7. Why is the shipping date used as the date of service and not the date the patient receives the supplies?**

**Answer:** The instruction to use the shipping date as the date of service if the supplier utilizes a shipping service or mail order is a CMS requirement per the Medicare Program Integrity Manual Chapter 4 located at: http://www.cms.gov/manuals/downloads/pim83c04.pdf

“If the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim.”

**Q8. Does the patient need to date the delivery slip?**

**Answer:** Yes, the patient or their designee should sign and date the delivery slip for items that are delivered directly to the beneficiary or picked up.

**Q9. A proof of delivery question, we send a postcard with our orders of diabetic supplies which has their name, signature and amount of quantity sent, why would we still be denied as no proof of delivery?**

**Answer:** Suppliers are to follow the proof of delivery requirements as outlined in the standard documentation language for local coverage determinations.

**Q10. If Medicare can audit up to ten years, should we keep the proof of delivery for ten years instead of seven?**

**Answer:** Medicare requires suppliers to maintain proof of delivery documentation in their files and that documentation must be maintained in the supplier's files for 7 years per the Program Integrity Manual. However, if you are still billing rentals or maintenance and service on an item older than 7 years, it is recommended to retain the documentation longer.
Q11. If you are missing a proof of delivery and discover this before an audit request is received and are in the process of picking up the equipment, what should you do?

Answer: Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Therefore, the claim will be subject to an overpayment via or a voluntary refund would be encouraged.

Q12. It was mentioned earlier in call that DOS is date beneficiary actually receives item, then it was stated if a shipping service is used the DOS is date of shipment. Please clarify?

Answer: In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim. If the supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Q13. When delivering a bone stimulator and patient is in hospital/SNF what is the correct date of service (date of delivery or date of discharge)?

Answer: A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two (2) days prior to the patient’s anticipated discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and shall use the place of service (POS) as 12 (patient’s home). The item must be for subsequent use in the patient’s home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Q14. Is pricing information required on the delivery tickets for each item being supplied?

Answer: No. Pricing information is not required on the delivery ticket.

Q15. If we utilize a delivery service such as FedEx, does the patient/designee have to sign for the package or is the service stating delivered considered a valid proof of delivery?

Answer: If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier’s own detailed shipping invoice and the delivery service’s tracking information. The supplier’s record must be linked to the delivery service record by some clear method like the delivery service’s package identification number or supplier’s invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary’s name
- Delivery address
• Delivery service’s package identification number, supplier invoice number or alternative method that links the supplier’s 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)
• Quantity delivered
• Date delivered
• Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim. Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Q16. We are contacting the patient 14 days in advance and shipping out prior to end date of the prior shipment so the patient does not run out of supplies. We were advised to bill the delivery date or date of shipment however that is prior to the end date of the prior bill and we are receiving denials, what is the correct date to bill, shipping date or next date needed?

Answer: For delivery via mail, you must use the shipping date as your date of service. You have a 10 day window to deliver supplies prior to the end of usage. However, keep in mind you should not be billing 10 days earlier each month, you should remain within a 10 day window from your original shipment date. (Example: If you shipped the initial supply on the 10th of the month, any shipment thereafter should fall between the 1st and 10th of the month.) The DME MACs are required to allow for processing of claims within this time frame. If you have received incorrect denials, please contact your DME MAC with an example.

Q17. Is a call from the recipient that is documented by the office sufficient proof of delivery?

Answer: No.

Q18. If we deliver to a facility / hospital (48 hours prior to discharge) and the patient is out of his/her room and hospital staff signs the delivery ticket. Is this sufficient?

Answer: Yes, this is acceptable. It is suggested that you document who signed on behalf of the patient. The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier should note the name of the designee on the delivery slip. However, the supplier must ensure that the beneficiary takes the item home, or you must pick up the item at the facility and deliver it to the beneficiary’s home on the date of discharge. For additional requirements, please refer to Chapter 20 of the Medicare Claims Processing Manual Section 110.3.1.

Q19. If the post office goes through with its proposed changes next year of eliminating Saturday delivery and reducing service for first class mail so that it will take 3 days for letters
now, will the beneficiary contact requirements change? If not, then beneficiaries will not have
time to process their re-orders without running out of supplies which could be dangerous.

Answer: The DME MACs do not have any information regarding changes to the requirements
based upon possible changes in USPS delivery schedules.

Q20. The proof of delivery via shipping service example shows only the city, state on the
delivery service tracking slip. Is this acceptable as long as the provider delivery slip shows the
full street delivery address? Or, does the delivery service tracking slip need to show the full
street delivery address? We have been told in the past that the delivery service tracking slip
must show the full street address.

Answer: Please see the response to question #15 in the proof of delivery section.

Q21. Does the proof of delivery slip need to have the beneficiary name typed on the form or is
just the beneficiary signature alone sufficient?

Answer: The beneficiary’s name and address should be provided on the form.

Q22. I thought if the patient had to stay past the 48 hours, you would need to get a letter from
the facility stating why the patient required further stay and then it would extend the
discharge date and the date of service vs. discharge date. Please clarify.

Answer: Per Chapter 4 of the CMS Program Integrity Manual: “ supplier may deliver a
DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training
the patient in the proper use of the item. This may be done up to 2 days prior to the patient’s
anticipated discharge to their home.” The PIM only allows for delivery up to two days prior to
discharge. If there is an unexpected delay in discharge they may have to pick up and re deliver if
the delay is prolonged (Undefined). A short delay would merely need a clear explanation in the
record.

Q23. If there is equipment that is provided in anticipation of discharge, and the beneficiary
was not released, there was mention of a pick-up and redelivery of the equipment on paper
only. When this process is followed, will the redelivered piece of equipment be allowed to be
billed as New, or will this now be used equipment, even though the beneficiary received a
new piece of equipment initially.

Answer: Yes, the equipment is still considered new in this circumstance and can be billed with
the NU modifier.

Q24. This is for a delivery of enteral feedings. At one time we were told that we could bill for
a 2 month supply on one billing claim. In this webinar there was a slide that stated we could
only bill a month at a time. Please clarify which it is can we bill for 45 days on one claim.
Answer: For refills of surgical dressings, enteral and parenteral nutrients and supplies, immnosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, external infusion pump drugs and supplies, and oral antiemetic drugs, no more than a one-month quantity of supplies may be dispensed. For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

Q25. We are having issues with proof of delivery for patients in nursing homes. We submit a usage report with patient names and detailed information regarding the products, signed and dated by a representative from the facility that the products have been delivered. Can you please give more detailed information regarding the requirements to meet proof of delivery for patients in a nursing home?

Answer: Regardless of the method of delivery used, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary’s use were actually provided to and used by the beneficiary must be available upon request.

Q26. When a patient is discharged from hospice to the home, do we need a new delivery ticket to continue billing for equipment that was previously in the patient’s home prior to their stay in Hospice?

Answer: Please refer to the break in service rules found in your Jurisdictions Supplier Manual.

Q27. When a beneficiary picks up diabetic testing supplies at a retail location, the receipt is considered consent and proof of delivery. If the beneficiary does not have to provide testing frequency and supplies on hand, how is the retail location documenting they are not dispensing on a predetermined basis?

Answer: The supplier must still have access to documentation to support the beneficiary had less than a 10 day supply remaining upon delivery. The receipt acts as proof of refill request but it does not document the amount of supplies remaining. Suppliers can create their own form or means of documenting this information.

Q28. If a supplier provides a high strength lightweight wheelchair (K0004), does the delivery ticket need to include all of the items included in the base equipment package (i.e., swingaway footrests (K0045), since these items are not separately billed to Medicare?

Answer: No, it only needs to include items which are separately billable to Medicare.

Q29. If hospice reports a date of death for the beneficiary, the beneficiary did not die but was simply discharged from hospice, how can a supplier have this corrected?
Answer: The beneficiary must contact Social Security to have the records updated.

Q30. If DMEPOS items are shipped to a beneficiary and they advise the shipment was not received, a new shipment of replacement items are sent, do suppliers have Medicare recoup the payments from the original shipment and submit a new claim for the replacement shipment?

Answer: The supplier should refund the initial date of service and rebill with the new shipping date as the date of service.

Q31. When is it appropriate to send a self-addressed envelope to obtain a beneficiary’s signature on shipped items?

Answer: Only if you are using return postage paid to meet proof of delivery requirements would this be required.

Q32. If a beneficiary cannot pick up their medications, can a minor come in to the pharmacy to pick-up?

Answer: No.

Q33. If a beneficiary is unable to sign proof of delivery must the individual who is signing advise why the beneficiary cannot sign?

Answer: It is not necessary to document why the patient is not signing but you must document the relationship.

Q34. What advice does Medicare have for a supplier that cannot obtain the pick-up slip from a previous supplier for a piece of rental equipment?

Answer: A pick-up slip is not required to begin billing the rental. Suppliers can contact the IVR to obtain the date last billed.