CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 612	**Date: September 10, 2015**
	Change Request 9063

Transmittal 611, dated August 28, 2015, is being rescinded and replaced by Transmittal 612 to include information from CR 9194, Transmittal 598, in section 5.8 that was erroneously omitted. All other information remains the same."

SUBJECT: Changes to Supplier Documentation and Evidence of Medical Necessity for Oxygen Claims

I. SUMMARY OF CHANGES: This purpose of this change request (CR) is to update the Program Integrity Manual instructions for supplier documentation, continued use and continued need, and evidence of medical necessity.

EFFECTIVE DATE: September 29, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 29, 2015
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5.8/Supplier Documentation
R	5.9.1/Evidence of Medical Necessity for the Oxygen Claims

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 612	Date: September 10, 2015	Change Request: 9063

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SUBJECT: Changes to Supplier Documentation and Evidence of Medical Necessity for Oxygen Claims

EFFECTIVE DATE: September 29, 2015
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I. GENERAL INFORMATION

A. Background: Contractors review documentation when making a determination on a claim. The contractors review the documentation for continued use and continued need, and evidence of medical necessity. When the documentation needed to support a claim is older than seven years and no longer available, the contractor shall not deny the claims solely on the missing documentation. The documentation provided to a contractor to support continued use and continued need should be timely, i.e., within the preceding 12 months. Claims for oxygen shall not be denied solely because the oxygen lab test results lack a physician signature.

B. Policy: This CR does not involve any legislative or regulatory policies and is restricted to changes in operational procedures.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9063.1	Contactors shall request Medicare qualifying documentation when reviewing claims for DME accessories and repairs.				X					CERT, RA, SMRC, ZPICs
9063.2	Contractors shall not deny the claim based solely on missing supporting Medicare qualifying supplier documentation that is over 7 years old.				X					CERT, RA, SMRC, ZPICs
9063.3	Contractors shall not deny an oxygen or oxygen equipment claim solely because the claim lacks a physician signature on the oxygen lab test result.				X					CERT, RA, SMRC, ZPICs
9063.4	DME MACs shall adjust their medical review strategy and				X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	medical review workloads as necessary to accommodate this change request as no additional funding will be provided.									
9063.4.1	DME MACs shall describe any necessary workload changes in detail, including the rational for these changes to their COR and medical review BFL.				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Debbie Skinner, 410-786-7480 or debbie.skinner@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 5 – Items and Services Having Special DME Review Considerations

Table of Contents
(Rev., Issued: 612-15)

5.8 - Supplier Documentation

(Rev. 612, Issued: 09-10-15, Effective: 09-29-15, Implementation: 09-29-15)

A. General

Before submitting a claim to the DME MAC the supplier must have on file a dispensing order, the detailed written order, the CMN (if applicable), the DIF (if applicable), information from the treating physician concerning the patient's diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DME MAC policies. The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained.

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

For DME accessories and repairs, the contractor shall request the Medicare qualifying documentation as normal.

B. Proof of Delivery

Suppliers are required to maintain proof of delivery documentation in their files. For the purpose of the proof of delivery noted below, **designee** is defined as:

"Any person who can sign and accept the delivery of DMEPOS items on behalf of the beneficiary."

Suppliers may deliver DMEPOS items directly to the beneficiary or the designee. The delivery ticket must be signed by the beneficiary or the designee upon delivery. The delivery ticket must also contain the date on which the DMEPOS item was delivered. The date of delivery may be entered by the beneficiary, designee, or supplier. The contractor shall not deny claims in which the date of delivery was completed by the supplier instead of the beneficiary or the designee. The date that the beneficiary received the DMEPOS supply shall be the date of service on the claim.

C. Proof of Delivery-Methods

The proof of delivery requirements are outlined below according to the method of delivery. Three methods of delivery are:

- Supplier delivering directly to the beneficiary or designee;
- Supplier utilizing a delivery/shipping service to deliver items; and
- Delivery of items to a nursing facility on behalf of the beneficiary.

D. Proof of Delivery-Availability

Proof of delivery documentation must be available to the DME MAC, Recovery Auditor, CERT and ZPIC on request. All items that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of CMPs or Administrative Sanctions.

E. Proof of Delivery for Recently Eligible Medicare FFS Beneficiaries

Medicare does not automatically assume payment for a DMEPOS item that was covered prior to a beneficiary becoming eligible for the Medicare FFS program. When a beneficiary receiving a DMEPOS item from another payer becomes eligible for the Medicare FFS program, the beneficiary may continue to receive such items only if Medicare requirements are met for such DMEPOS items. The DME MAC shall educate the supplier community that the supplier must submit an initial or new claim for the item and the necessary documentation to support Medicare payment upon request to the DME MAC even if there is no change in the beneficiary's medical condition. The proof of delivery serves as evidence that the beneficiary is already in possession of the item. The beneficiary's signature is required on the proof of delivery. A date of delivery must be noted by the supplier, beneficiary, or designee. The first day of the first rental month in which Medicare payments are made for the item serves as the start date of the reasonable useful lifetime and period of continuous use. The DME MAC shall consider the proof of delivery requirements met for this type of beneficiary by instructing the suppler to obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item. The DME MAC shall educate the supplier that the supplier must also attest to the fact that the item meets Medicare requirements.

5.9.1 - *Evidence of Medical Necessity for the Oxygen Claims*

(Rev. 612, Issued: 09-10-15, Effective: 09-29-15, Implementation: 09-29-15)

If DME MACs, CERT, ZPICs, Recovery Auditors or the SMRC learn that the physician of record is no longer the treating physician, the supplier shall obtain from the physician currently responsible for the patient's pulmonary condition a current fully-completed oxygen CMN. After review of this oxygen CMN, DME MACs continue monthly payments if the evidence establishes medical necessity. Their records must be updated to identify the new treating physician.

For an initial claim, the physician must submit a signed certification of medical necessity that includes an oxygen/blood gas lab result. This certification must be corroborated with information in the medical record. A physician signature on the oxygen lab test result is not necessary to corroborate the certification. Instead, the reviewer should consider all submitted records from all of the beneficiary's healthcare professionals.

Therefore, contractors shall not deny an oxygen or oxygen equipment claim solely because the claim lacks a physician signature on the oxygen lab test result.