Power Mobility Device (PMD) Demonstration Operational Guide

04/24/2013

F. Amendments, Corrections, Addenda and Late Entries to Progress Notes, Orders and Other Medical Documentation

G. Progress Notes and Templates

The purpose of the PMD Demonstration Operational Guide is to interpret and clarify the documentation responsibilities for Medicare participating suppliers and providers when ordering a PMD for Medicare beneficiaries. These guidelines are merely to assist and explain the documentation requirements that are set forth in CMS National Coverage Policy (CMS Pub. 100-3, Medicare National Coverage Determinations NCD) Manual, Chapter 1, Section 280.3) and the Local Coverage Determination (LCD) Policy (http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html).

Chapter 1: Power Mobility Device (PMD) Benefit

For any item to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

The Local Coverage Determination (LCD) for each jurisdiction describes in further detail the circumstance under which a PMD will be covered by Medicare.

Medicare covers scooters and power wheelchairs (called PMDs) when:

- It is needed by the beneficiary to perform activities of daily living in the home
- Other devices (canes, walkers, manual wheelchairs) are not sufficient

Complete coverage and documentation requirements are outlined in the following policies:

- National Coverage Determination (NCD) for PMD
- LCDs for PMD
  - Jurisdiction A LCD (including NY)
  - Jurisdiction B LCD (including IL, MI)
  - Jurisdiction C LCD (including FL, NC, TX)
  - Jurisdiction D LCD (including CA)
  - CMS MLN Matters Article provides further guidance and clarification about documentation for physicians and treating practitioners when ordering PMDs

Chapter 2: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the Prior Authorization Demonstration

A. PMD Base HCPCS Codes

The following PMD base HCPCS codes are subject to prior authorization under the demonstration:

- All power operated vehicles (K0800-K0802 and K0812)
- All standard power wheelchairs (K0813-K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835-K0843)
- All group 3 complex rehabilitative power wheelchairs without power options (K0848-K0855)
- All pediatric power wheelchairs (K0890-K0891)
- Miscellaneous power wheelchairs (K0898)

Note: Group 3 complex rehabilitative power wheelchairs with power options (K0856 thru K0864 are excluded.

PMD Accessories

- Under the demonstration, all documentation to support a prior authorization request must meet all applicable rules, policy, and NCD/LCD requirements. The LCD states that for certain bases, the coverage criteria for certain accessories/options must be met to meet coverage criteria for the base. Therefore, when requesting prior authorization for those chair bases with power options (detailed in the LCD) the appropriate supporting documentation as outlined in the LCD to support the base should also be submitted as part of the prior authorization request.

C. Prior Authorization request received for a code not listed in Section A

- No prior authorization decisions will be made on any code NOT on this list. If a DME MAC receives a prior authorization request for a code not on this list, the DME MAC will not review the request and will not issue a decision letter.

Chapter 3: Demonstration Overview

A. Who

The physician/ treating practitioner or suppliers may submit the Prior Authorization request.

B. Where

This 7 state demonstration is based on the beneficiary's state of residence as reported to the Social Security Administration. The 7 states are:

- California
- Florida
- Illinois
- Michigan
- New York
- North Carolina
- Texas

If a beneficiary needs to update the address on file at Social Security, the beneficiary can:

- Go online: https://secure.ssa.gov/apps6z/ICOA/coa001.jsp
- Call at 1-800-772-1213 (TTY 1-800-325-0778) between 7 a.m. to 7 p.m., Monday through Friday.
- Contact the local Social Security office
- What the beneficiary will need:
    - Complete new address, including zip code.
    - Provide a new phone number or a number to be contacted at.

C. When

Physicians and suppliers are encouraged to utilize the prior authorization process for all PMDs when the 7-element order is signed on or after September 1, 2012. Suppliers should place the unique tracking number on claims submitted for these PMDs. DME MACs will ramp up reviews of claim submitted without the unique tracking number based on date of service.

The demonstration will end for PMDs where the 7-element order is signed on or after September 1, 2015.

Chapter 4: Documentation Requirements

A. The face-to-face examination documentation

1. Content that should be included in the progress note documenting the face-to-face examination.

See the MLN Checklist and LCD for PMDs for more details about what a provider needs to include in this documentation.

- Jurisdiction A LCD (for beneficiaries residing in NY)
- Jurisdiction B LCD (for beneficiaries residing in IL, MI)
- Jurisdiction C LCD (for beneficiaries residing in FL, NC, TX)
- Jurisdiction D LCD (for beneficiaries residing in CA)

2. Tools/interfaces that assist physicians/practitioners in documenting a progress note.

See Appendix G for definitions and guidelines about tools/interfaces that assist in documenting a progress note.

Physicians/practitioners may also wish to keep in mind that CMS is exploring the development of a Suggested Electronic Clinical Template that would allow electronic health record vendors to create prompts to assist physicians when documenting the Power Mobility Device (PMD) face-to-face encounter for Medicare purposes. The first draft is available in the Download section of go.cms.gov/eclinicaltemplate.

3. Amendments, Corrections, Addenda and Late Entries to Progress Notes, Orders and Other Medical Documentation.

See Appendix F for a description of how to review documents that contain amendments, corrections, addenda and late entries to progress notes, orders and other medical documentation and failure to comply with recordkeeping principles.

B. 7 element order

1. Beneficiary's name
2. Description of the item that is ordered. This may be general – e.g. "power operated vehicle", "power wheelchair", or "power mobility device" – or may be more specific
3. Date of face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. Date of physician signature

C. Detailed product description

- Must be completed by the supplier, and reviewed and signed by the treating physician;

- Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed;
- Narrative description of the items or manufacturer name and model name/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;
- Physician signature and date signed; and
- Date stamp to document receipt date.

D. Other Relevant Documentation if necessary

Chapter 5: Submitting a Request

A. Submitters are encouraged to include the following data elements in a Prior Authorization (PA) request package:

Beneficiary Information

- Beneficiary Name,
- Beneficiary Medicare Number (also known as HICN), and
- Beneficiary Date of Birth

Physician/Practitioner Information

- Physician/Practitioner Name,
- Physician/Practitioner National Provider Identifier (NPI), and
- Physician/Practitioner Address

Supplier Information

- Supplier Name,
- Supplier NSC Number,
- Supplier NPI, and
- Supplier Address

Other Information

- HCPCS Code,
- Submission Date, and
- Indicate if the request is an initial or subsequent review

Submitters should note that the **beneficiary and supplier** addresses listed in the PA Request **will not** be used by the DME MACs when sending review decision letters. The decision letters for suppliers and beneficiary will be mailed to the address files within VMS. However, the **physician/practitioner** address listed in the PA Request **will** be used by the DME MACs when sending review decision letters.

Submitters should also note that CMS has not mandated a fax cover sheet for submitters to use. However, the following DME MACs have created OPTIONAL fax cover sheets for submitters who wish to use them:

- Jurisdiction A fax cover sheet (for beneficiaries residing in NY)
- Jurisdiction B fax cover sheet (for beneficiaries residing in IL, MI)
- Jurisdiction C fax cover sheet (for beneficiaries residing in FL, NC, TX)
- Jurisdiction D fax cover sheet (for beneficiaries residing in CA)

B. Include the following documentation in a PA request package

1. Face-to-face documentation
2. 7-element order
3. Detailed Product Description
4. Any other necessary clinical information

C. Methods for sending a PA request package

Beginning September 1, 2012, submitters have two options for submitting PA requests to the DME MACs: 1) mail or 2) fax.

Beginning January 2013 submitters will have three options for submitting PA requests to the DME MACs: 1) mail, 2) fax, or 3) electronic submission of medical documentation (esMD).

Jurisdictions A, B, C and D are accepting PA requests via esMD.

For more information about esMD, see www.cms.gov/esMD or contact your DME MAC.

See below for addresses and fax numbers of the DME MACs.

- For beneficiaries residing in CA, send requests to DME MAC D at:
  - Fax Number: 701-277-7891
  - Street Address: NAS
    PO Box 6742
    Fargo, ND 58108-6742
  - esMD: (indicate document type "8")

- For beneficiaries residing in IL send requests to DME MAC B at:
  - Fax Number: 317-841-4414
  - Street Address: Medical Review-PMD Prior Authorization Request
    P.O. Box 7018
    Indianapolis, IN 46207-7018
  - esMD: (indicate document type "8")

- For beneficiaries residing in MI send requests to DME MAC B at:
  - Fax Number: 317-841-4414
  - Street Address: Medical Review-PMD Prior Authorization Request
    P.O. Box 7018
    Indianapolis, IN 46207-7018
  - esMD: (indicate document type "8")

- For beneficiaries residing in NY send requests to DME MAC A at:
  - Fax Number: 781-383-4519
  - Street Address: NHIC
    75 Sgt. William B. Terry Drive
    Hingham, MA 02043
  - esMD: (indicate document type "8")

- For beneficiaries residing in FL send requests to DME MAC C at:
  - Fax Number: 615-664-5960
  - Street Address: CGS-DME Medical Review-Prior Authorization
    P.O. Box 24890

Nashville, TN 37202-4890
- esMD: (indicate document type "8")

- For beneficiaries residing in NC: DME MAC C:
  - Fax Number: 615-664-5960
  - Street Address: CGS-DME Medical Review-Prior Authorization
    P.O. Box 24890
    Nashville, TN 37202-4890
  - esMD: (indicate document type "8")

- For beneficiaries residing in TX: DME MAC C:
  - Fax Number: 615-664-5960
  - Street Address: CGS-DME Medical Review-Prior Authorization
    P.O. Box 24890
    Nashville, TN 37202-4890
  - esMD: (indicate document type "8")

D. General Process

1. Possible Outcomes of Review.

The DME MAC will review the request and either:

- Affirm the request (Chapter 6) or
- Non-affirm the request (Chapter 7)
  - Incomplete request

2. Cases where Medicare is primary and another insurance company is secondary.

Suppliers may submit the claim without a prior authorization decision if the claim is for a denial of not medically necessary (GA modifier), non-covered (GY modifier), or no 7-element order (EY and GA modifier). A prior authorization is not needed and the claim will not be developed due to the prior authorization demonstration.

If a supplier chooses to use the prior authorization for a denial then the following process is to be followed:

- The submitter may submit the **prior authorization request** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the PMD, then a non-affirmative prior authorization decision will be sent to the physician and treating practitioner, supplier and Medicare beneficiary advising them that Medicare will not pay for the item.
- After receiving a non-affirmative decision for the prior authorization request, and a **claim** is submitted by the supplier to the DME MAC for payment it will be denied.
- The submitter or Medicare beneficiary may forward the denied claim to his/her secondary insurance payee as appropriate to determine payment for the PMD.

3. Cases where another insurance company is primary and Medicare is secondary.

If a supplier plans to bill another insurance first and bill Medicare second, the submitter and beneficiary have 2 options:

a. Seek Prior Authorization

- The submitter submits the **prior authorization request** with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the PMD, then an affirmative prior authorization decision will be sent to the physician/practitioner, supplier and Medicare beneficiary advising them that Medicare **will** pay for the item.
- The supplier delivers the item and submits a **claim** to the **other insurance company**.
- If the other insurance company denies the claim, the supplier can submit a claim to the DME MAC (listing the PA tracking number on the claim). The DME MAC will pay the claim.

b. Skip Prior Authorization

- Deliver the item. Submit a claim to the primary payer for a determination as appropriate.
- DME MAC will stop claim for review. DME MAC will send an ADR letter. Supplier should respond to the ADR.

4. Timeframe for Decisions.

The DME MAC will postmark notification of the decision to the practitioner, supplier and beneficiary within 10 business days for an initial request. For resubmitted requests the DME MAC will postmark notification of the decision to the practitioner, supplier and beneficiary within 20 business days.

5. Physicians/treating practitioners Telephone Inquires

- Physicians/treating practitioners and suppliers who have questions about the PMD prior authorization process should call the appropriate DME MAC. The numbers for Customer Service Representatives at the DME MACs are as follows
    - For beneficiaries residing in CA, call 1-877-320-0390; TTY/TDD 1-866-879-2704.
    - For beneficiaries residing in IL or MI, call 1-866-590-6727; TTY/TDD 1-888-897-7534.
    - For beneficiaries residing in NY, call 1-866-590-6731; TTY/TDD 1-888-897-7539.
    - For beneficiaries residing in FL, NC, TX, call 1-866-270-4909; TTY/TDD 1-888-204-3771.

See Appendices A-E

Chapter 6: An Affirmative Request

A. Decision Letter (s)

The DME MAC will send decision letters with the affirmative PA number to the submitter, physician, and Medicare beneficiary within 10 business days.

B. Transferability of an affirmative PA Decision

An affirmative PA decision follows the beneficiary. It is the beneficiary's choice as to which supplier will deliver the PMD and bill Medicare. In the event a beneficiary changes suppliers after an affirmative decision is made a new 7 element order (see PIM section 5.2.4) is required. The newly selected supplier must comply with all Medicare documentation and claim submission requirements (e.g., number of days between the order and the delivery, etc.) as outlined in the PMD LCD.

C. Supplier's Actions

- Ensure that home assessment is complete.
- Deliver the item to beneficiary.
- Document proof of delivery.
- Get patient authorization.
- Have all documentation available on request.
- Submit the claim with the tracking number on the claim.
    - The submission of the prior authorized PMD claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim, the unique tracking number is submitted in Item 23 of the 1500 Claim Form. For electronic claims the unique tracking number is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).
    - If all requirements are met the claim will be paid.
    - The prior authorization demonstration has specific parameters for pre-payment review; however other contractors (CERT, ZPICs, RACs, etc.) may have parameters outside of the PA demonstration that will suspend the same claim for another type of review. If your claim is selected for review, guidance and directions will be provided on the Additional Documentation Request Letter from the requesting contractor.

See Appendix B: Request Process for PMD (Supplier Submits)

Chapter 7: A Non-Affirmative Request

An incomplete request is considered non-affirmed. When an incomplete request is submitted:

- The DME MAC will provide notification of what is missing through a detailed decision letter postmarked within 10 business days for initial request and 20 business days for resubmitted request of the review to all parties affected.
- The submitter may resubmit another complete package with all documentation required as noted in the detailed decision letter. See Chapter 8 for instructions on resubmitting a PA request. If the PA was non-affirmed because a data element was missing from the progress note documenting the face-to-face evaluation, physicians should be mindful of CMS' guidance on Amendments, Corrections, Addenda and Late Entries in Medical Documentation in Appendix F.

- If the claim is submitted by the supplier to the DME MAC for payment with a non-affirmative prior authorization decision, it will be denied.
    - All appeal rights are then engaged.
    - This claim could then be submitted to secondary insurance.

Clerical Error

If a DME MAC verifies that a clerical error was made by the review staff when reviewing the PA request and the decision was non-affirmative as a result of this error, the DME MAC has the sole discretion to determine whether to change the decision to affirmative. The clerical error in question must be present and legible in the documentation already in the DME MAC's possession. If not, the supplier must resubmit the PA request for a subsequent review and decision (e.g. the date of the face to face examination was overlooked in the PA request package and the supplier contacted the DME MAC to inform them this information is present in the PA request package. Based on this information the DME MAC reviewed the PA request and confirmed the clerical error. The information was present and legible in the PA request as stated by the supplier. In this instance the DME MAC may change the decision and sent an affirmed decision to the supplier).

Physicians/treating practitioner's actions:

- Monitor the beneficiary for a future submission.
    - If the clinical condition of the beneficiary changes, complete and submit a new prior authorization request.

- Use the detailed decision letter to ensure that the request package complies with all requirements.
    - Resubmit a prior authorization request, if appropriate.

Suppliers Action:

- Use the detailed decision letter to ensure that the request package complies with all requirements.
    - Resubmit a prior authorization request, if appropriate.

- Submit the claim (with the tracking number) for a denial.
    - All appeal rights are then engaged.
    - This claim could then be submitted to secondary insurance.

Chapter 8: Resubmitting a Prior Authorization Request

- The submitter should review the detailed decision letter that was provided.

- The submitter should make whatever modifications are needed to the prior authorization package and follow the submission procedures.

- The DME MAC will provide notification of the decision through a detailed decision letter postmarked within 20 business days of the review(s) to all parties affected.

Chapter 9: Claim Submission Where PA was Sought

A. Cases Where a PA Request was Submitted and Affirmed.

- The submission of the prior authorized PMD claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim, the unique tracking number is submitted in Item 23 of the 1500 Claim Form. For electronic claims the unique tracking number is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).

- Series of claims:
  - Should be submitted with the prior authorization tracking number on the claim.
  - Should be submitted to the applicable DME MAC for adjudication.
  - If the supplier changes during the 13 month rental period, the claim will undergo a complex medical review (ADR). The new supplier is required to submit all medical documentation to support an affirmative PA decision.

- Moving during a series of claims
  - If a beneficiary changes jurisdictions during a rental series and the supplier is the same, the DME MACs will work together to ensure the PA decision follows the beneficiary. In some cases the supplier may be asked for the decision letter to verify the information. However if the change in jurisdiction also means a change in supplier then a new 7 element written order is required (See PIM Chapter 5.2). A new prior authorization request is needed if there is a new order.

B. Cases Where a PA Request was Submitted and Non-Affirmed.

- The submission of the prior authorized PMD claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim, the unique tracking number is submitted in Item 23 of the 1500 Claim Form. For electronic claims the unique tracking number is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).

- Series of claims:
  - Should be submitted with the prior authorization tracking number on the claim.
  - Should be submitted to the applicable DME MAC for adjudication.

See Appendix D-PMD Base Claim Line Process (if PA was sought)

Chapter 10: Claim Submission Where PA was NOT Sought: The Prepayment Review and Payment Reduction Process

- If an applicable claim is submitted without a prior authorization decision, it will be stopped for review and a payment reduction may apply. Claims with orders written before September 1, 2012 are not applicable for the prior authorization demonstration. DME MACs will ramp up reviews of claim submitted without the unique tracking number based on date of service. Once fully ramped up, all initial claims submitted without a unique tracking number will be stopped for review and a payment reduction may apply.

- At this time, suppliers do not need to do anything differently when submitting a claim without a unique tracking number. They do not need to put any information in the remarks field. They do not need to submit any unsolicited documentation.

A. Stopping a Claim for Review.

- The DME MAC will stop the claim and send an Additional Documentation Request (ADR) through the US Postal Service.
    - The supplier will have 45 days to respond to the ADR with all requested documentation.
    - The supplier can send the documentation via:
        - Fax
        - Mail
        - Effective __/__/2012, esMD (for more information see: www.cms.gov/esMD)
- The DME MAC will review the claim.

B. Payment Reduction May Apply.

- If the claim is payable the DME MAC will determine if the supplier is a competitive bid supplier.
    - If yes, the claim (and the remainder of the series) will be paid at the single payment amount.
    - If no, the claim (and the rest of the series) will automatically be assessed a 25 percent reduction of the Medicare payment after co-insurance and deductible. There was a 3-month grace period before the payment reduction rule applies. Thus, the payment reduction began for orders written on or after December 1, 2012.
        - This payment reduction is not transferable to the beneficiary.

- This payment reduction is not appealable.

- The payment reduction applies only to the base HCPCS codes (e.g., the codes listed in Chapter 2 Section A). The payment reduction does NOT apply to accessories, even if billed on the same claim.

- Suppliers should keep in mind that they can avoid the prepayment review and the possible payment reduction by submitting a PA request in cases where the physician has not already done so.

C. Retroactive Medicare Eligibility

- Beneficiaries with retroactive Medicare eligibility status may have a Medicare PA request submitted on their behalf to the DME MAC for payment reimbursement due to change in their Medicare status. If a PA request is submitted, the supplier is not subject to the 25 percent payment reduction or prepayment review. However, the supplier seeking reimbursement shall indicate that the PMD has been delivered, that Medicare coverage is retroactive and submit all necessary PA request documentation to support the medical necessity of the item. If a claim is submitted without first going through PA it will be stopped for review.

See Appendix E-PMD Base Claim Line Process (if PA was not sought)

Chapter 11: The G-Code

- Physician/Practitioner can bill G9156 after he/she submits an initial Prior Authorization Request.
    - G-code is billed to the A/B MAC contractors with the Prior Authorization tracking number.
    - Only one G-code may be billed per beneficiary per PMD even if the physician/ practitioners must resubmit the request.
    - Code is not subject to co-insurance and deductible.
    - Physicians may not bill the G-code in instances where the supplier submits the Prior Authorization Request
    - Suppliers may not bill the G-code.

- The new G9156 code can be billed IN ADDITION TO:
    - the existing G0372 code that physicians/practitioners can bill to provide additional reimbursement to recognize the additional time and effort that are required to provide documentation to the supplier,
    - the E&M visit code

Chapter 12: Upgrades

The PMD that meets the medical necessity outlined in the medical policy is what is reported on the Prior Authorization request. The medical records documentation must justify the PMD for which the beneficiary qualifies, not the item that is considered for the upgrade. Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-08) Chapter 5. For example, if a beneficiary meets the coverage criteria for a K0823, the Prior Authorization submitted should be for the K0823 and the medical records documentation would support the K0823. After medical necessity is established for the PA requested PMD, the process to provide an upgrade may be started.

If in fact, an upgrade is to be provided it is suggested that the supplier note on the DPD that an upgrade is being supplied.

Suppliers may refer to the "Upgrade Billing for Power Mobility Devices" and Revised-Use of Upgrade Modifiers" articles published on the four DME MAC web pages for further guidance concerning upgrades.

- DME MAC JA
- DME MAC JB
- DME MAC JC
- DME MAC JD

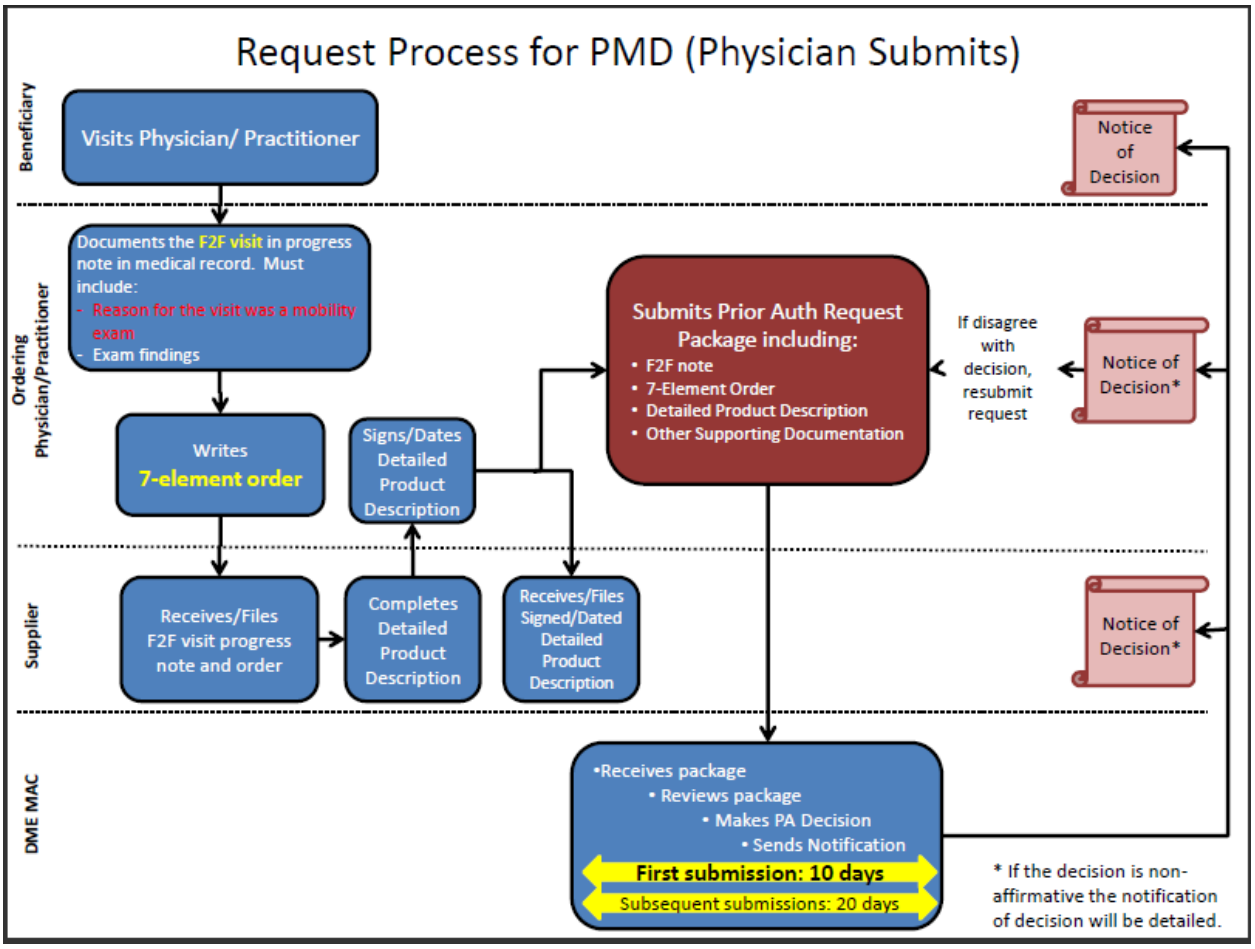
Chapter 13: Claim Appeals

Appeals follow all current procedures. For further information consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision.

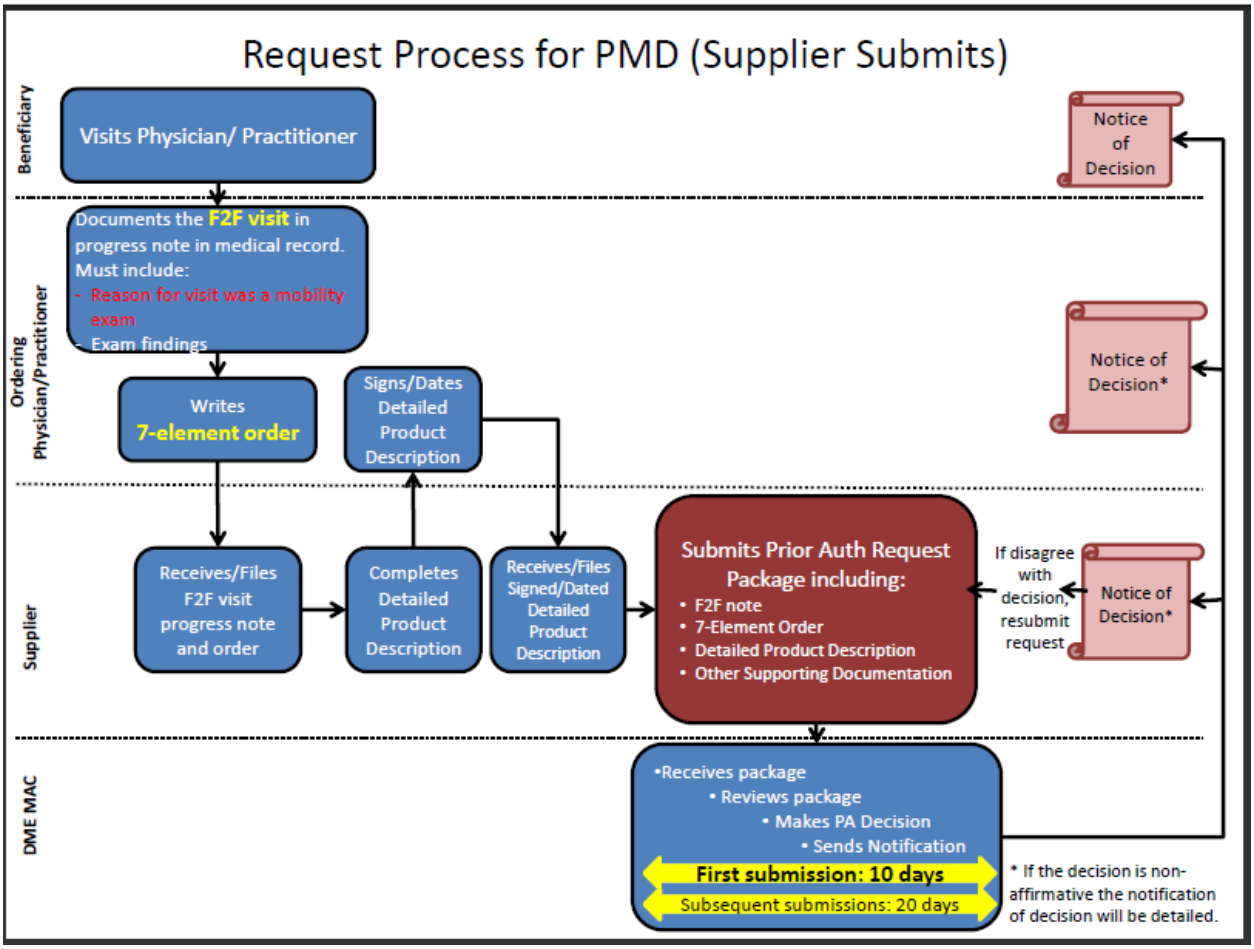
This demonstration does not include a separate appeal process for a non-affirmative prior authorization request decision. However, a non-affirmative prior authorization request decision does not prevent the supplier from submitting a claim. Such a submission of a claim and resulting denial by the DME MAC would constitute an initial determination what would make the appeals process available for Medicare beneficiaries and suppliers disputes.

The 25 percent payment reduction, which applies for failure to receive a prior authorization decision before submission of a claim, is non-transferrable to the beneficiary. This payment reduction, which will begin December 1, 2012 in each state, is not subject to appeal.

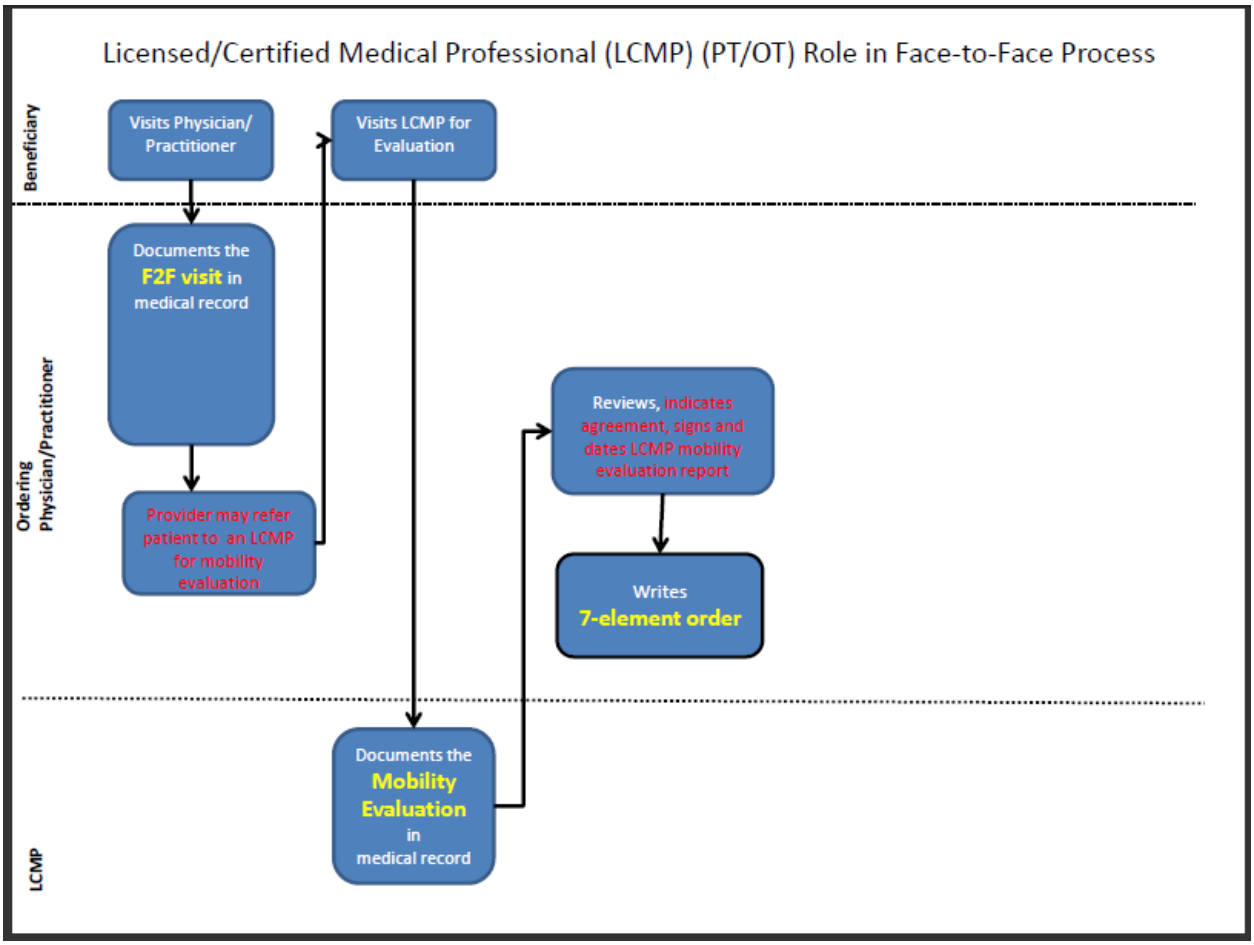
Appendix A: Request Process for PMD (Physician Submits)



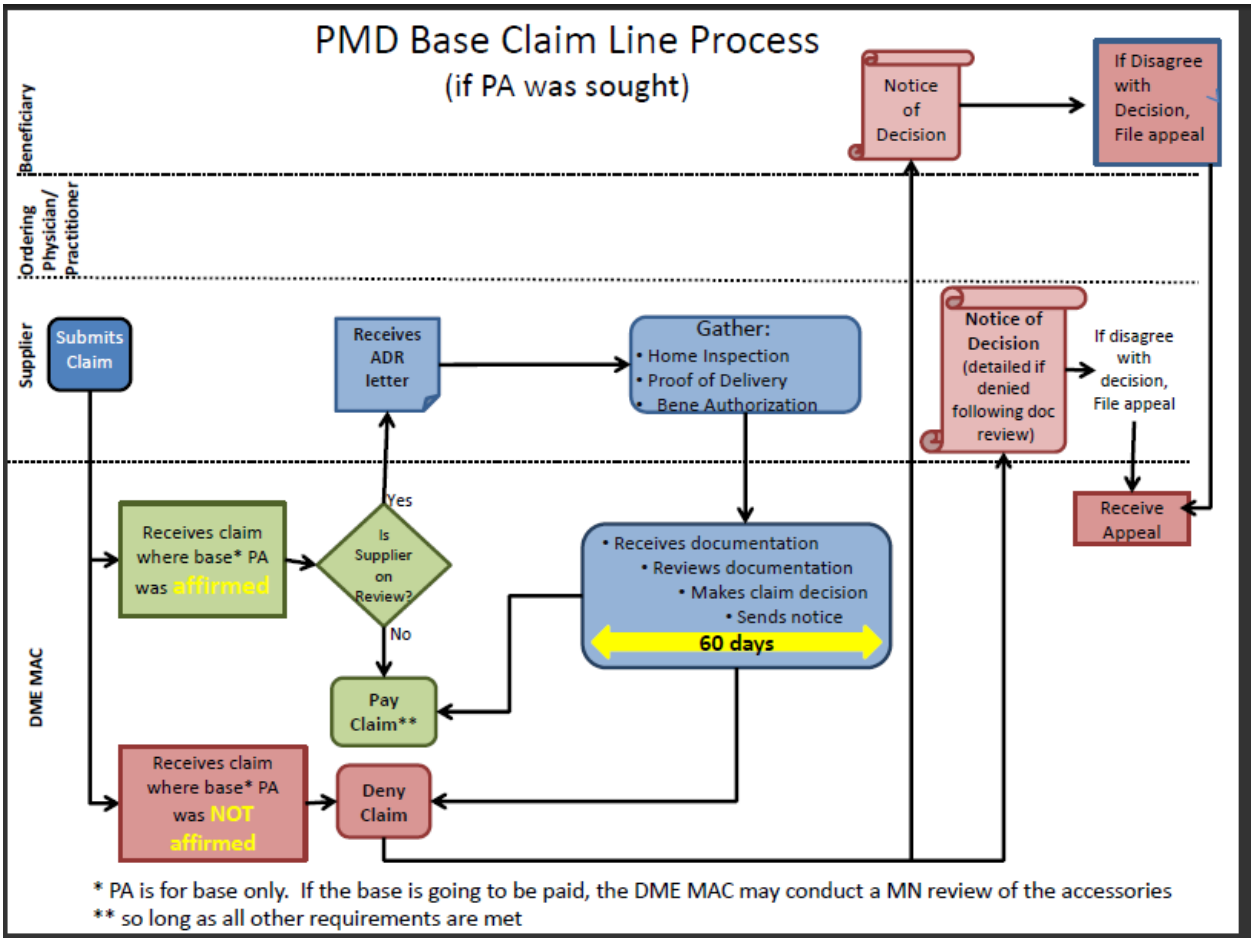
Appendix B: Request Process for PMD (Supplier Submits)



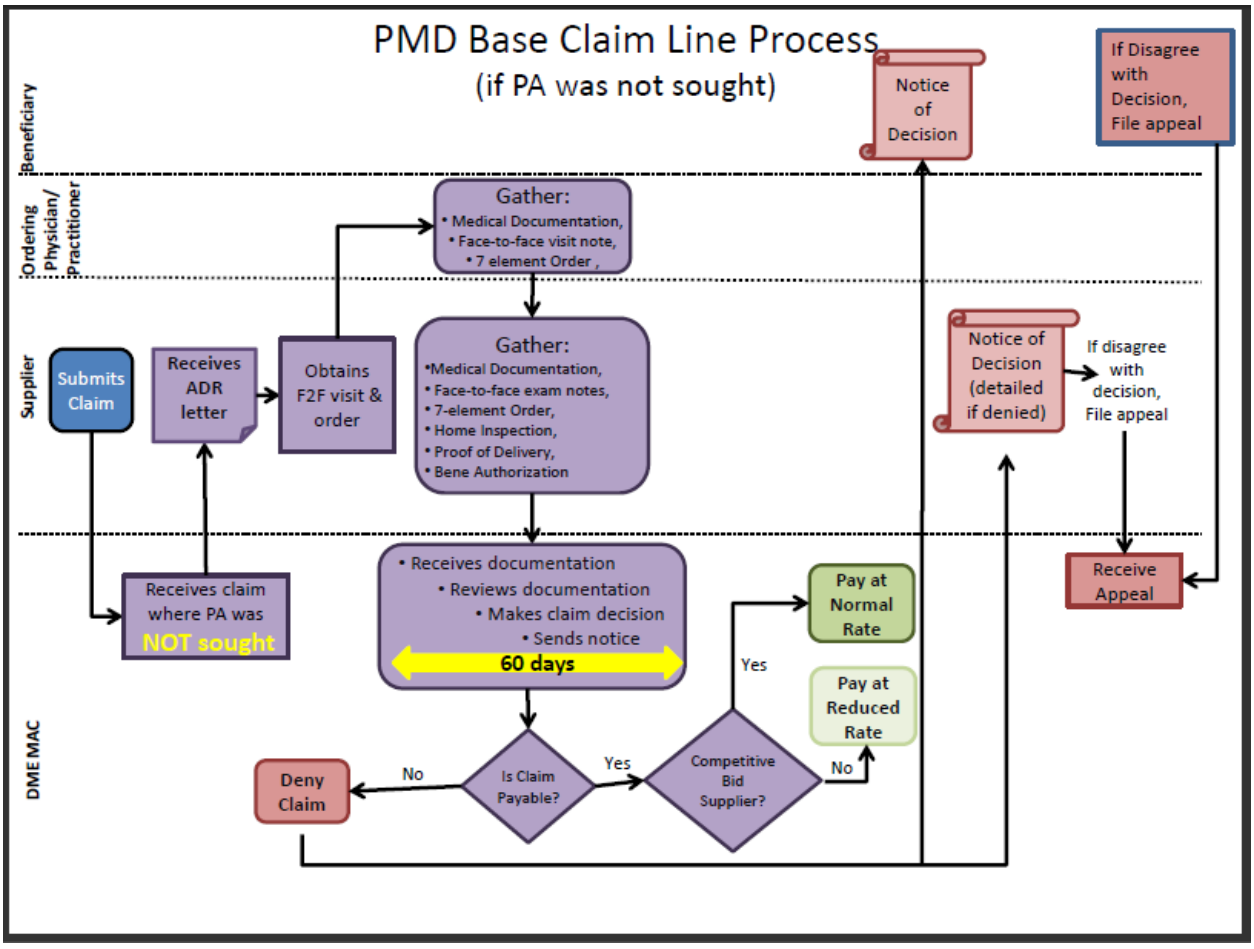
Appendix C: Licensed/Certified Medical Professional (LCMP) (PT/OT) Role in Face-to-Face Process



Appendix D: PMD Base Claim Line Process (if PA was sought)



Appendix E: PMD Base Claim Line Process (if PA was not sought)



Appendix F: Amendments, Corrections and Delayed Entries to Progress Notes, Orders and Other Medical Documentation

A. Amendments, Corrections and Delayed Entries in Medical Documentation

Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service. When making a *review determination*, the DME MACs *shall* consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in section B below. *However, the DME MACs shall give less weight to an amendment, correction or delayed entry made after the date of submission of a related claim or prior authorization request. This should not be construed to discourage or prevent the submission of a subsequent prior authorization request.* The DME MACs *shall* NOT consider any entries that do not comply with the principles listed in section B below, even if such exclusion would lead to a claim denial. For example, they shall not consider undated or unsigned entries handwritten in the margin of a document. Instead, they shall exclude these entries from consideration.

Additionally, a corrected 7-Element-Order is acceptable only when the correction is made prior to the completion of any Detailed Product Description (DPD). Furthermore, the correction must be completed prior to the Date of Delivery of the item.

Please note: It is always best to completely re-write an incomplete or inaccurate order so that there is no question about the intended order.

B. Recordkeeping Principles

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to a DME MAC containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and

2. Clearly indicate the date and author of any amendment, correction or delayed entry, and

3. Not delete but instead clearly identify all original content

Paper Medical Records: When correcting a paper medical record, these principles are generally accomplished by using a single line strike through so that the original content is still readable. Further, the author of the alteration must sign and date the revision. Similarly, amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record.

Electronic Health Records (EHR): Medical record keeping within an EHR deserves special considerations; however, the principles noted above remain fundamental and necessary for document submission to a DME MAC. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry, and

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

C. If a DME MAC identifies medical documentation with potentially fraudulent entries, the reviewers shall refer the case to the ZPIC and may consider referring to the RO and State Agency.

Appendix G: Progress Notes and Templates

A. Definitions

1. "Progress Notes" -- visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record. Progress notes may be in any form or format, hardcopy or electronic.

2. "Template" -- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.

3. "Electronic records" may involve any type of interface including but not limited to:

- simple electronic documents,
- sophisticated graphical user interfaces (GUIs) with clinical decision and documentation support prompts, or
- electronic pen capture devices.

4. "Licensed/Certified Medical Professional (LCMP)" – medical professional licensed or certified to practice in the state in which services are rendered. For the purpose of the documenting DMEPOS items, a physician or LCMP must not have a financial relationship with the DMEPOS supplier.

B. Guidelines Regarding Which Documents DME MAC Will Consider

The DME MAC shall consider all medical record entries made by physicians and LCMPs. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation.

The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the Local Coverage Determination for further details.

CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.

Some templates provide limited options and/or space for the collection of information such as by using "check boxes," predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physician/LCMPs should be aware that templates designed to gather <u>selected</u> information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents do not provide

sufficient information to adequately demonstrate that the medical necessity criteria for the item/service are met.

If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to **select one that allows for a full and complete collection of information** to demonstrate that the applicable coverage and coding criteria are met.

CMS recommends that the physician/LCMP document in their usual medical record keeping format.

Certificates of Medical Necessity (CMN), DME Information Forms (DIF), supplier prepared statements and physician attestations by themselves do **NOT** provide sufficient documentation of medical necessity, even if signed by the signed by the ordering physician. These types of documents will **NOT** be considered by the contractor when making a coverage/coding determination. See PIM §5.7 for additional information on documentation.

Supplier-prepared statements and records (even if signed by the ordering physician) and physician attestation letters (e.g. Letters of Medical Necessity), are NOT considered to be part of a medical record for Medicare payment purposes. Review contractors shall NOT consider this type of documentation when making a coverage/coding determination.

C. Financial Liability

The physician/LCMP should be aware that inadequate medical record documentation can lead to a financial liability for the Beneficiary and/or Supplier, should the reviewer determine that the claim is not supported.

In addition, the physician/LCMP should be aware when ordering an item or service that will be furnished by another entity, Section 1842(p)(4) of the Social Security Act requires that adequate documentation supporting medical necessity be provided to the entity at the time that the item or service is ordered. Physicians/LCMPs who fail to submit documentation upon a supplier's request may trigger increased DME MAC review of the physician/LCMP's evaluation and management services.