CERT

DME MAC OUTREACH & EDUCATION

Task Force for Error-Free Medicare Claims

Documentation Requirements

June 18, 2024

Noridian Healthcare Solutions

CGS A CELERIAN GROUP COMPANY

Disclaimer

The DME MAC CERT Outreach and Education Task Force consists of representatives from each of the DME MACs and is independent from the CMS CERT Team and CERT Contractors, who are responsible for the calculation of the Medicare Fee-for-Service Improper Payment Rate.

The DME MAC CERT Outreach and Education Task Force has produced this material as an informational reference for providers furnishing services in our contract jurisdictions. The CERT Task Force employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov.

Webinar Moderators and Presenters

- Jurisdiction A and D – Noridian Healthcare Solutions
  - Shelly Carlson
- Jurisdiction B and C – CGS Administrators
  - Judie Roan

Agenda

- Comprehensive Error Rate Testing (CERT) Data
- Documentation Requirements
- Resources
- Questions

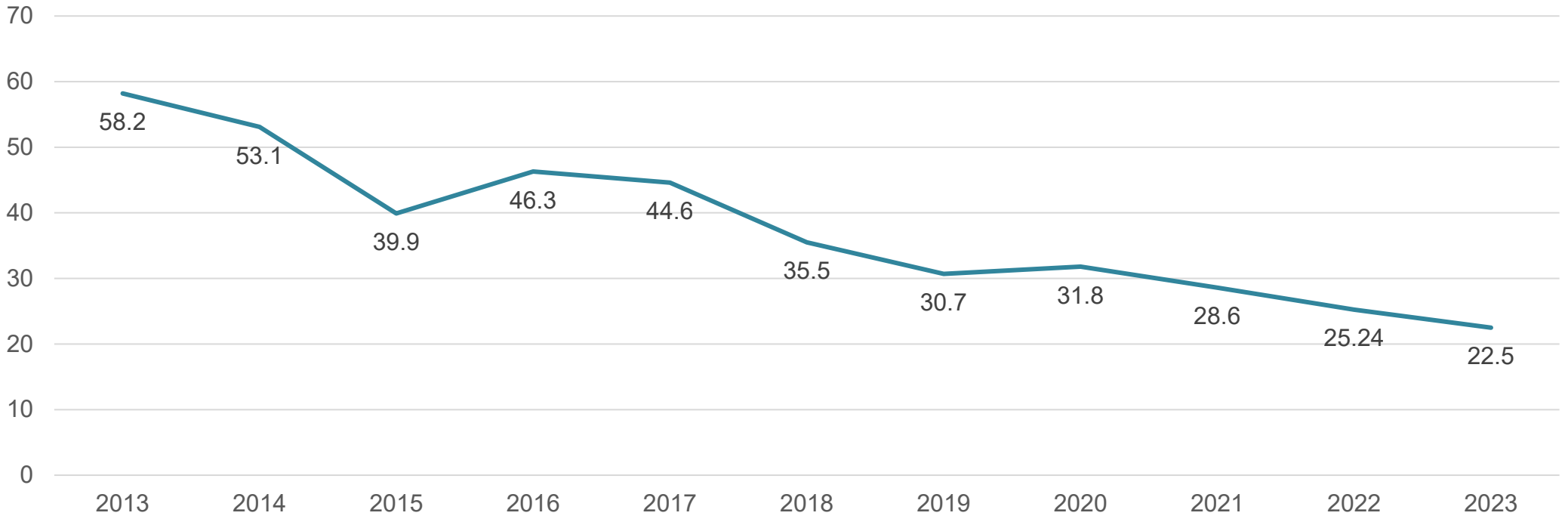
Comprehensive Error Rate Testing (CERT) Data

CERT

2023 Improper Payment Rates and Projected Improper Payment
https://www.cms.gov/files/document/2023medicarefee-servicesupplementalimproperpaymentdatapdf.pdf

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.4%	$31.2 B
★**DMEPOS**	★**22.5%**	★**$1.9 B**
Part A (excluding Hospital Inpatient Prospective Payment System (IPPS)	7.8%	$14.2 B
Part A (Hospital IPPS)	3.4%	$4.1 B
Part B Providers	10.0%	$11.0 B

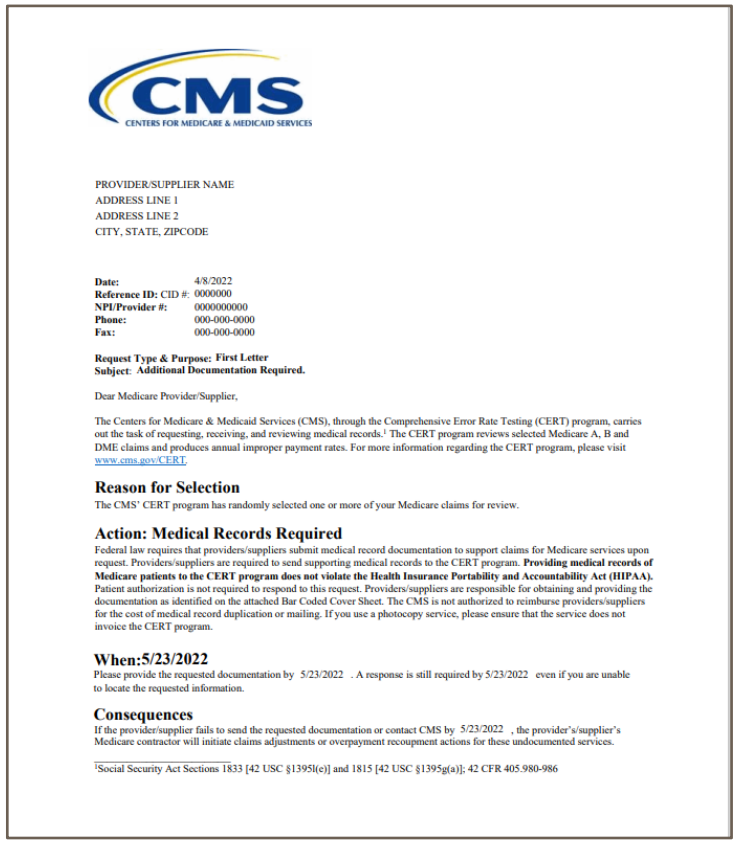
DMEPOS Improper Payment Rate All DME MAC Trend



Top Root Causes of Improper Payments

Root Cause Description
Documentation to support coverage criteria - missing/inadequate
Documentation to support continued medical need - missing
Order - missing/inadequate
Order not written by provider listed on the claims as ordering/ referring provider
Refill request - missing/inadequate
Units of service (UOS) ordered does not support the units of service (UOS) provided and billed
Proof of delivery - missing/inadequate
Proof of delivery the date of delivery was not supported by the submitted documentation

CERT Letter



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER/SUPPLIER NAME
ADDRESS LINE 1
ADDRESS LINE 2
CITY, STATE, ZIPCODE

Date: 4/8/2022
Reference ID: CID #: 0000000
NPI/Provider #: 0000000000
Phone: 000-000-0000
Fax: 000-000-0000

Request Type & Purpose: First Letter
Subject: Additional Documentation Required.

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

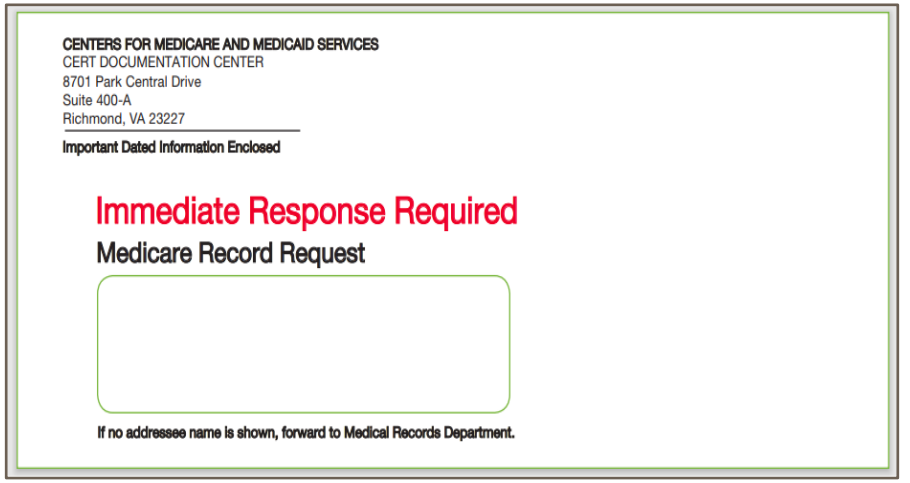
When:5/23/2022

Please provide the requested documentation by 5/23/2022 . A response is still required by 5/23/2022 even if you are unable to locate the requested information.

Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by 5/23/2022 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

[1]Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986



CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
8701 Park Central Drive
Suite 400-A
Richmond, VA 23227

Important Dated Information Enclosed

Immediate Response Required

Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

CERT Documentation Requests

- The CERT Review Contractor requests and receives all medical records
- Use the barcoded coversheet as your documentation coversheet
- Documentation may be submitted:
  - Mail or Fax
  - Electronic Submission of Medical Documentation (esMD)
    - Include a CID number or Claim number and the barcoded cover sheet in your file transmission
    - Information on esMD can be found at https://www.cms.gov/esMD
  - CD or Email attachment
    - encrypted per HIPAA security rules
- Check the current status of a claim under CERT review by using the CERT C3HUB Claim Status Search https://c3hub.certrc.cms.gov/
  - If CERT shows the review has been completed – refer to DME MAC CERT resources

CERT Contact Information

CERT Contractor Resources and Contacts

- Phone: 1.888.779.7477 or 1.443.663.2699
- E-mail: certprovider@empower.ai
- Website: C3HUB (https://c3hub.certrc.cms.gov/)

DME MAC CERT Resource Locations

- JA: https://med.noridianmedicare.com/web/jadme/cert-reviews/cert
- JB: https://www.cgsmedicare.com/jb/claims/cert/index.html
- JC: https://www.cgsmedicare.com/jc/claims/cert/index.html
- JD: https://med.noridianmedicare.com/web/jddme/cert-reviews/cert

Appeal Rights from CERT Audits

- If the CERT contractor finds errors with the claim in question, the supplier will receive an Overpayment Demand Letter and a revised Medicare Remittance Advice (MRA).
- If the supplier does not agree with the outcome of the CERT review, they should file an appeal to the Redeterminations department of their DME MAC within 120 days of the date on the demand letter or MRA.
  - If a Redetermination is filed to the appropriate DME MAC within 30 days of the letter/MRA, all recoupment activities will cease until the redetermination decision is made.

Documentation Requirements

Medical Records

CERT Errors

Documentation to support coverage criteria – missing or inadequate

Documentation to support continued medical need – missing

Documentation Requirements

- Standard Written Order (SWO) or Written Order Prior to Delivery (WOPD)
- Beneficiary Authorization
- Advance Beneficiary Notice of Noncoverage (ABN) (when applicable)
- Refill Documentation (when applicable)
- Information required for use of specific modifiers
- Clinical documentation to support medical need and continued use of the item
- Proof of Delivery

Medical Records

- The medical records include:
  - The treating practitioner's office records
  - Hospital records
  - Nursing home records
  - Home health agency records
  - Records from other healthcare professionals and test reports
- Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary
- Supplier-produced records, even if signed by the treating practitioner, and attestation letters (e.g., letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes

Documentation in the Beneficiary's Medical Record

- Should substantiate the medical necessity for the item, quantity ordered, and frequency of use
- Should include (but **is** not limited to):
  - Beneficiary's diagnosis
  - Duration of condition
  - Clinical course
  - Prognosis
  - Nature and extent of functional limitations
  - Other therapeutic interventions and results
  - Past experience with related items, etc.
- All documentation must be maintained in your files for seven years and be available upon request

CMS Signature Requirements

- Services provided/ordered/certified must be identifiable by the persons responsible for the care of the beneficiary in accordance with Medicare's policies:
  - Handwritten
  - Electronic
  - Stamp signatures are typically not acceptable unless the practitioner has physical disability.
- Medicare contractors shall consider the totality of the medical record when reviewing
- CMS Signature Requirements:
  - CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.4: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf
  - MLN Fact Sheet "Complying with Medicare Signature Requirements" https://www.cms.gov/mln905364-complying-with-medicare-signature-requirements

Initial Need Documentation

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

Documentation Continued Need/Continued Use Supplies and Rented Items

Continued Need

TIMELY: Within the preceding 12 months (unless specified per policy)

Continued Need Documentation
A recent order by the treating practitioner for refills
A recent order/prescription by the treating practitioner for repairs
A recent change in the order/prescription
Timely documentation in the medical record showing usage of items

Continued Use

TIMELY: Within the preceding 12 months (unless specified per policy)

Continued Use Documentation
Timely documentation in the medical record showing usage of the item(s), related **options**/accessories, and supplies
Supplier records documenting requests for refill/replacement of supplies in compliance with the refill documentation requirements (this is deemed to be sufficient to document continued use for the base item as well)
Supplier records documenting beneficiary's confirmation of continued use of a rental item

Amendments and Corrections to Medical Records

- All services are expected to be documented in the medical record at the time they are rendered.
- If services provided were not properly documented, documentation may need to be amended, corrected or entered after rendering the service.
- Medical records amended, corrected, or entered after the service should note:
  - The date and author and
  - Change/addenda should be clearly and permanently denoted
- CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.5: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03pdf.pdf

Orders

CERT Errors

Missing or Inadequate

Submitted order not written by provider listed on the claims as ordering/ referring provider

Orders/Prescriptions

- All claims require a written order/prescription from the treating practitioner
  - Written order/prescription = Standard Written Order (SWO)
  - Written Order Prior to Delivery (WOPD) = SWO received prior to delivery
  - Required face-to-face encounter and written order prior to delivery list
    - https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf

Required Face-to-Face and Written Order Prior to Delivery List

- CMS maintains the Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List: https://www.cms.gov/files/document/required-face-face-encounter-and-written-order-prior-delivery-list.pdf
  - Forty-six Power Mobility Devices (PMDs) are on the list as dictated by statute: K0800 - K0808, K0813 - K0816, K0820 - K0829, K0835 - K0843, and K0848 - K0864
  - Spinal Orthosis: L0631, L0637, L0648, and L0650
  - Knee Orthosis: L1832, L1833, L1843, and L1851
  - Ankle-Foot/Knee - Ankle Foot Orthosis: L1932, L1940, L1951, L1960, L1970, L2005, and L2036
  - Shoulder/Wrist Hand Orthosis: L3960
  - Osteogenesis Stimulator: E0748
- Items on this list require:
  - Face-to-Face Encounter within six months preceding the order and
  - Written Order Prior to Delivery (WOPD)

Updates to the Written Order Prior to Delivery (WOPD) and Face-to-Face Encounter (F2F) List

On May 13, 2024, CMS announced updates to the Master List and Required Face-to-Face (F2F) Encounter and Written Order Prior to Delivery (WOPD)

- **Effective August 12, 2024**, CMS selected additional codes that require a F2F Encounter and WOPD:
  - Lumbar-Sacral Orthoses
    - L0635, L0636, L0638, L0639, L0640, L0651
  - Knee Orthoses:
    - L1845, L1852
  - Hospital Beds:
    - E0290, E0301, E0304
  - Osteogenesis Stimulators:
    - E0747, E0760
- Effective August 12, 2024, ***L1833 (knee orthosis) no longer requires a WOPD and F2F***

Written Order Prior to Delivery (WOPD)

A WOPD is a completed SWO that is communicated to the supplier before delivery of the item

- Items appearing on the Required List require a Face-to-Face (F2F) encounter and WOPD
- The date of the WOPD shall be on or before the date of delivery
  - Must be completed within 6 months after the required F2F encounter
  - For items other than Power Mobility Devices (PMDs), someone other than the treating practitioner may complete certain required elements of the SWO
- F2F encounter and WOPD requirements are statutorily required for PMDs
  - Must be completed within six months before the date on the written order/prescription
  - The WOPD must be completed by the treating practitioner
- MLN Matters Number: SE20007 https://www.cms.gov/files/document/se20007.pdf

Face-to-Face Encounter

- The treating practitioner must document and communicate to the DMEPOS supplier that they had a face-to-face encounter with the patient within the 6 months before the date on the written order/prescription
  - The 6-month timing requirement doesn't replace other CMS policies
- In-person or telehealth encounter between the treating practitioner and the patient
  - Telehealth encounter must meet the requirements of 42 CFR 410.78 and 42 CFR 414.65
- Supporting documentation includes subjective and objective information associated with diagnosing, treating, or managing a clinical condition for the DMEPOS item ordered
- Suppliers must maintain the written order/prescription, and the supporting documentation provided by the treating practitioner to support payment for the item(s) of DMEPOS and make them available to CMS or its contractors upon request

SWO/WOPD Elements

A SWO must include all required elements:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item
- Quantity to be dispensed, if applicable
- Treating practitioner name or NPI
- Treating practitioner's signature

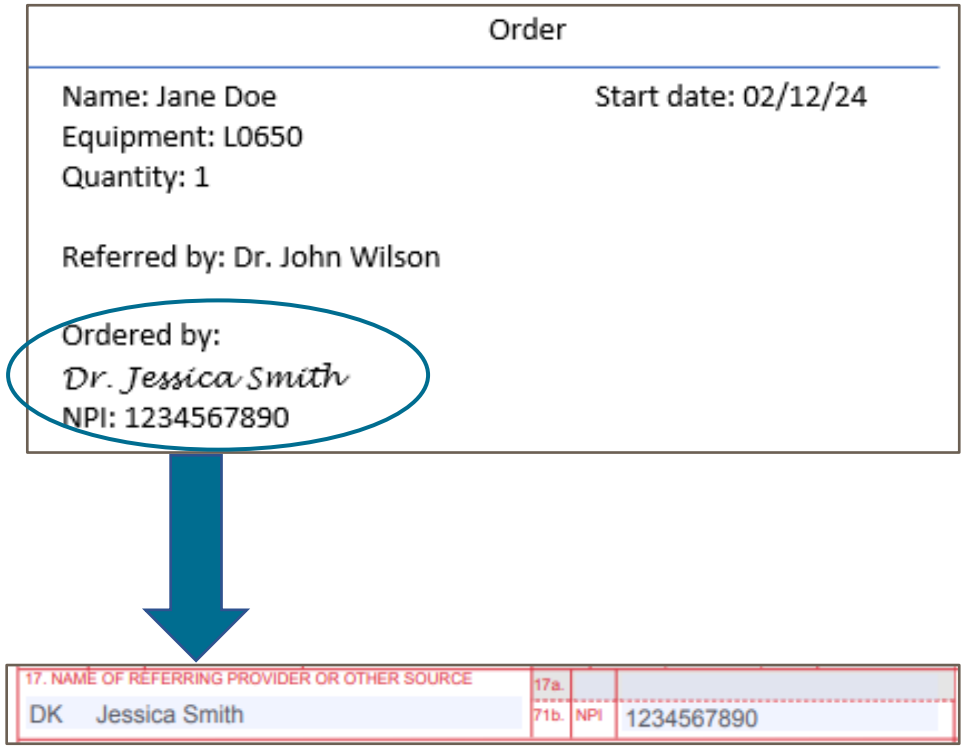
SWO/WOPD Description

- The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number.
- For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories, or additional features that are separately billed or require an upgraded code (list each separately).
- For supplies - In addition to the description of the base item, the order/prescription may include all concurrently ordered supplies that are separately billed (List each separately).

Entering the Correct Ordering Practitioner on Claims

To help reduce CERT errors:

- When there is more than one practitioner involved in the beneficiary's care:
  - Enter the ordering practitioner's information on the claim
    - Enter the practitioner’s name and National Provider Identifier (NPI)
      - > This is the practitioner that created the order



Refill Request

CERT Errors

Missing or Inadequate

Refill Documentation Requirements

Refill Documentation Requirements for dates of service prior to January 1, 2024

Obtained In Person @ Retail Store	Written Request From Beneficiary	Telephone Contact Between Supplier and Beneficiary
Signed delivery slip or copy of itemized sales receipt	Beneficiary name and/or authorized rep *(indicate relationship)*	Beneficiary name and the name of person contacted *(if someone other than the beneficiary include this person's relationship to the beneficiary)*
Delivery slip/receipt should indicate items were picked up		
	Date of request	Date of contact
	Description of each item requested	Description of each item requested
	Quantity/functional condition of each item still remaining	Quantity/functional condition of each item still remaining
	Contact no sooner than 14 calendar days prior to delivery/shipping	Contact no sooner than 14 calendar days prior to delivery/shipping
	Shipment/delivery occur no sooner than 10 calendar days prior to current supply exhausting	Shipment/delivery occur no sooner than 10 calendar days prior to current supply exhausting

Refill Requests

Medicare Program Integrity Manual (PIM) Chapter 5 Section 5.2.6:
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c05.pdf

For refill requests on or after January 1, 2024:

- Suppliers must obtain documentation of beneficiary's affirmative response indicating a need for the refill
  - Removed: Suppliers must document quantity/functional condition of each item remaining
- Suppliers must document the beneficiary has confirmed their need for refill no sooner than 30 calendar days prior to the expected end of the current supply
  - Removed: Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date

Refill Documentation Requirements: Final Rule CMS1780-F

Refill Documentation Requirements for dates of service **on or after** January 1, 2024

Obtained In Person @ Retail Store	**Delivered Refill Communications**
Signed delivery slip or copy of itemized sales receipt	Beneficiary name and/or authorized representative *(Suggested: if someone other than the beneficiary include this person's relationship to the beneficiary)*
Delivery slip/receipt should indicate items were picked up at store front	
	Date of request
	Description of each item requested
	Documentation of affirmative response indicating a need for the refill
	Contact must occur no sooner than 30 calendar days prior to the expected end of the current supply
	Shipment/delivery occur no sooner than 10 calendar days prior to expected end of current supply

Proof of Delivery

CERT Errors

Missing or Inadequate

The date of delivery was not supported by the submitted documentation

Proof of Delivery Methods

- **Three methods of delivery:**
  - Method 1 – Direct Delivery to the Beneficiary by the Supplier
  - Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
  - Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary
- **Regardless of the method of delivery, the contractor must be able to determine that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) were received by a specific beneficiary.**
- Delivery by the supplier
  - Suppliers, their employees, or anyone else having a financial interest in the delivery of the item(s) are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary)

Method 1: Direct to Beneficiary

Proof of Delivery (POD) must include:

- Beneficiary's name
- Delivery address
- The quantity delivered
- A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number
- Date delivered
- Beneficiary (or designee) signature

DATE OF SERVICE = DATE OF DELIVERY

Method 2: Shipping Service

The Proof of Delivery (POD) must include:

- Beneficiary's name
- Delivery address
- Delivery service's package ID number, supplier invoice number or alternative method that links supplier's delivery documents with delivery service's records
- A description of the item(s) being delivered. The description can be either a narrative description, a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
- Quantity delivered
- Date delivered
- Evidence of delivery

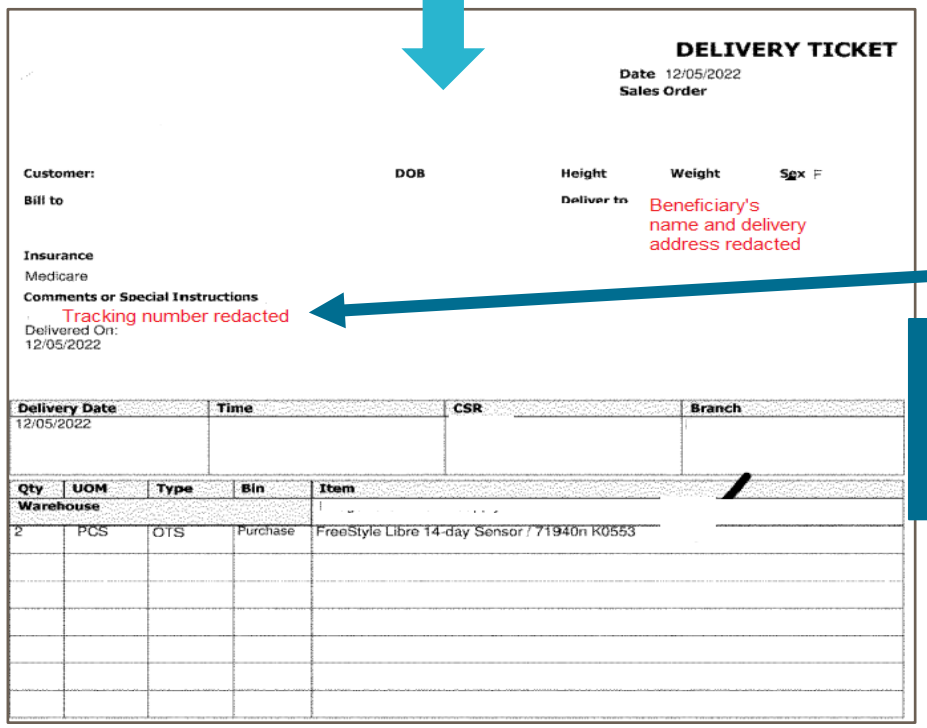
DATE OF SERVICE = SHIPPING DATE, LABEL CREATION DATE, OR DATE OF DELIVERY

Valid Proof of Delivery Example: Method 2 Shipping Service

Shipping Invoice has beneficiary's name, delivery address, description of item(s), quantity shipped

Tracking slip has delivery address, date shipped, and date delivered

The tracking number links invoice to tracking slip



DELIVERY TICKET

Date 12/05/2022
Sales Order

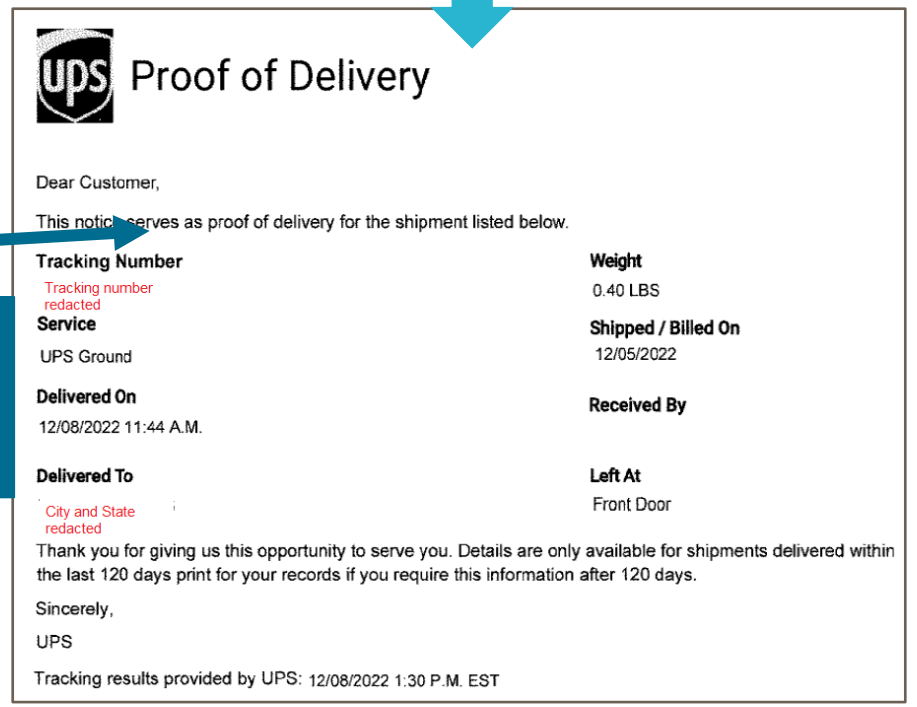
Customer: DOB Height Weight Sex F
Bill to Deliver to

Beneficiary's name and delivery address redacted

Insurance
Medicare
Comments or Special Instructions
Tracking number redacted
Delivered On:
12/05/2022

Delivery Date	Time	CSR	Branch
12/05/2022			

Qty	UOM	Type	Bin	Item
Warehouse				
2	PCS	OTS	Purchase	FreeStyle Libre 14-day Sensor / 71940n K0553



Proof of Delivery

Dear Customer,

This notice serves as proof of delivery for the shipment listed below.

Tracking Number
Tracking number redacted

Weight
0.40 LBS

Service
UPS Ground

Shipped / Billed On
12/05/2022

Delivered On
12/08/2022 11:44 A.M.

Received By

Delivered To
City and State redacted

Left At
Front Door

Thank you for giving us this opportunity to serve you. Details are only available for shipments delivered within the last 120 days print for your records if you require this information after 120 days.

Sincerely,

UPS

Tracking results provided by UPS: 12/08/2022 1:30 P.M. EST

Method 3: Delivery to Skilled Nursing Facility

Proof of Delivery (POD) must include:

- Documentation demonstrating delivery of the item(s) to the facility by the supplier or delivery entity; and,
- Documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the beneficiary. The quantities delivered and used by the beneficiary must justify the quantity billed.

DATE OF SERVICE = SHIPPING DATE OR DATE OF DELIVERY

Equipment Retained From a Prior Payer

A POD is required for all items submitted to Medicare, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility

- The supplier record must document:
  - A statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item, meets the POD requirements; and
  - A supplier attestation that the item meets Medicare requirements

Thank You!