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Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F

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Effective Date: January 1, 2020
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PROVIDER TYPES AFFECTED

This MLN Matters Article is for Durable Medical Equipment (DME) suppliers billing DME Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items and for providers ordering DMEPOS for Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11599 revises the Medicare Program Integrity Manual, Chapters 3 (Verifying Potential Errors and Taking Corrective Actions) and 5 (Items and Services Having Special DMEPOS Review Considerations) to include finalized regulatory updates, including those related to face-to-face encounter and written order requirements.

BACKGROUND

On November 8, 2019, the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1713-F, entitled: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Amounts, DMEPOS Competitive Bidding Program (CBP) Amendments, Standard Elements for a DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements.

You can find this /Final Rule at https://www.federalregister.gov/documents/2019/11/08/2019-24063/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis.

CR 11599 reflects these policy changes and conditions of payment updates, which became

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effective on January 1, 2020.

SE 19030 informed providers that the Calendar Year (CY) 2020 End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Final Rule CMS-1713-F (84 Fed. Reg Vol 217) (https://www.federalregister.gov/documents/2019/11/08/2019-24063/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis), went into effect January 1, 2020.

CMS-1713-F, in part, streamlines the requirements for ordering DMEPOS items through the identification of a standard set of elements to be included in a written order/prescription.

In addition, the rule established a Master List that shall serve as a library of DMEPOS items from which items may be selected for inclusion on the Required Face-to-Face Encounter and Written Order Prior to Delivery List and/or the Required Prior Authorization List. If an item is included on the Required Face-to-Face Encounter and Written Order Prior to Delivery List, it is subject to such requirements as a condition of payment. Due to the statutory requirements defined in Section 1834(a)(1)(E)(iv)) of the Act, all Medicare covered PMDs will be included and remain on the Required Face-to-Face Encounter and Written Order Prior to Delivery List. For such items, medical review contractors shall ensure that the defined Face-to-Face encounter (and per the regulation, written order prior to delivery) requirements are met.

The final rule also notes that Section 1834(h)(3) of the Social Security Act (the Act) requires that Section 1834(a)(11) of the Act apply to orthotics and prosthetics in the same manner as it applies to items of DME. The final regulation revised sections 42 CFR 410.36 and 410.38 to clarify the inclusion of orthotics and prosthetics in the DME payment requirements outlined in 42 CFR 410.38.

This MLN advises providers and suppliers that the updates became effective, January 1, 2020, and your medical review contractor will review claims for payment of DMEPOS items in accordance with this Final Rule.

What Medical Review Contractors will look for upon review:

I. For All DMEPOS Items

In conducting their reviews of DMEPOS claims for payment, in accordance with recent Final Rule CMS-1713-F, medical review contractors:

1. Will look for the presence of a written order/prescription, or a written communication from a treating practitioner, documenting the need to provide a beneficiary an item of DMEPOS.
    a. We note that all DMEPOS items require a written order/prescription from the treating practitioner for Medicare payment as a condition of payment).
    b. The written order/prescription must be communicated to the supplier prior to claim submission.

c. In those limited instances in which the treating practitioner is also the supplier and is permitted to furnish specific items of DMEPOS and fulfill the role of the supplier in accordance with any applicable laws and policies, a separate SWO is not required. However, the medical record must still contain all of the required SWO elements.

2. Will verify that the written order/prescription includes the following elements:
   a) Beneficiary Name or Medicare Beneficiary Identifier (MBI)
   b) General Description of the item
   c) Quantity to be dispensed, if applicable
   d) Order Date
   e) Treating Practitioner Name or NPI
   f) Treating Practitioner Signature

   You should note that, while not required for inclusion in the order for payment purposes, the frequency of change, route of administration, and/or duration of need may help support the medical necessity of the item.
3. Will consider the totality of the medical records when reviewing for compliance with SWO/prescription elements. For example, a contractor should nonetheless support payment when an order has a missing or flawed element that is clearly documented elsewhere in the record.

II. For DMEPOS items appearing on the Required Face-to-Face and Written Order Prior to Delivery List, medical review contractors additionally assess the following:

1. Will verify that the date of the written order is on, or before, the date of delivery or date shipped, if the shipping date is used as the date of service.
2. Will verify that the treating practitioner has had a face-to-face encounter with the beneficiary within the 6 months preceding the date of the written order/prescription. The face-to-face encounter means an in-person or telehealth encounter between the treating practitioner and the beneficiary.

   Note: that the 6-month timing requirement does not supplant other CMS policies. For example, the National Coverage Determination, Section§ 240.2 “Home use of Oxygen” requires a face-to-face examination within a month of starting home oxygen therapy.

3. Will verify, to the extent possible, that telehealth encounters used to satisfy the face-to-face requirement for DMEPOS items also meet the requirements of 42 CFR 410.78 (Telehealth Services) and 414.65 (Payment for Telehealth Services), which you is at https://www.govregs.com/regulations/title42_chapterIV_part410_subpartB_section410.78 and https://www.govregs.com/regulations/expand/title42_chapterIV_

part414_subpartB_section414.65#title42_chapterIV_part414_subpartB_section414.65, respectively.

4. Will verify the face-to-face encounter documentation provides subjective and objective information associated with diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.

   Note: Suppliers are expected to maintain, and upon request, provide the face-to-face documentation, as well as the written order/prescription, and the supporting documentation provided by the treating practitioner to support payment for the item(s) of DMEPOS.

ADDITIONAL INFORMATION

The official instruction, CR 11599, issued to your medical review contractor regarding this change is available at https://www.cms.gov/files/document/r10190pi.pdf. The revised Chapters 3 and 5 of the Program Integrity Manual are part of CR 11599. Complete details of the changes are in those chapters.

If you have questions, your medical review contractor may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
July 1, 2020	Initial article released.