General DME/HME Medicare Reimbursement Guidance

Our website, http://hmebillers.com, provides easy to understand product level cheat sheets, physician order forms, documentation checklists, and CMS approved training handouts for most DMEPOS products covered by Medicare. We encourage our customers to consult these resources, located in the password protected customer portal section of the website, on a regular basis. They are updated when CMS reimbursement regulations change. These resources are focused on CMS rules because generally, CMS rules are the most restrictive, and are adopted by many private insurance payers and most Medicaid programs.

In addition to the product level resources, we have also prepared this general guidance document in order to provide an overview of important components of DMEPOS reimbursement regulations, and common DME company processes that are applicable to most products. Our hope is that this general guidance handout will inform you, and encourage you to consult the product level resources on our website for additional details that are applicable to various CMS covered DMEPOS items.

Documentation requirements:

1. CMS has clearly stated that patient medical records (physician notes, hospital, home health and other health care provider documentation.) are the determining factor as to whether a patient meets CMS qualifying criteria for a particular product. Supplier generated physician order forms that include questions about CMS qualifying criteria are NOT sufficient as the sole medical documentation required to meet medical necessity criteria. CMS expects that physician and other health care provider progress notes will contain the information necessary to fully document that the patient meets the coverage criteria required by the CMS medical policy for a specific covered item.

We provide detailed written order forms for specific products that you can use in place of generic order forms generated by your HME software system. In many cases you can load these custom forms into your software system so that they can be printed with the relevant patient information, physician information, diagnosis codes obtained on intake, and other required information.

Be aware, they are not intended to take the place of physician progress notes, but rather to remind the ordering / treating physician of the product specific qualifying criteria each and every time they sign an order. These forms should only be used in conjunction with clear instructions to the ordering/treating practitioner about CMS documentation requirements as they pertain to progress notes and other medical documentation.

Some DME suppliers choose not to use such order forms because they believe it may lead the physician referral source to conclude that no other documentation is necessary. DME suppliers can, instead, use the order forms or the product level cheat sheets to create cover letters that inform physicians of the medical necessity documentation requirements.

2. CMS has termed it a “business decision” as to whether a DME supplier decide to obtain physician or other health care provider progress notes that justify medical necessity criteria prior to delivering a product or billing a claim (except in the case of power mobility devices). In other words, you are permitted to bill a claim with only the product specific documentation on file, as required by the specific medical policy for the product you providing.

If you choose to do this, you are taking it on faith that the physician or other healthcare provider’s notes support the medical necessity criteria. If you have trained your referral sources well, this may be a reasonable decision to make. However, suppliers should be aware that progress notes created after the date of service for the product provided will not be considered as supporting medical necessity for previously billed dates of service in an audit or appeal situation.
3. For patients receiving DMEPOS products after a recent hospital admission the most recent history and physical assessment dictated by the physician after treating the patient in the hospital often includes information that addresses the medical necessity of the equipment provided upon discharge. In addition, it documents that a recent physician evaluation has been completed, and is fairly easy for the referral source to provide. We advise our clients to request the most recent H&P when providing most DMEPOS products. Unfortunately, the H&P rarely includes the full medical necessity documentation for manual wheelchairs – specifically why a less expensive ambulatory aide such as a cane or walker is insufficient to adequately resolve a patient’s mobility deficit.

4. Physician referral sources may resist your request for the extensive medical necessity documentation that CMS auditors will require DME suppliers to provide in an audit or appeal situation. Your physician referral source might insist that other DME suppliers do not require as much documentation from them as you are requesting. This may be accurate since it is a “business decision” made by the DME supplier. DME suppliers should understand that physician referral sources typically chart notes in the patient medical record to remind themselves of their care plan for the patient; not to satisfy CMS that their medical orders are justified.

DME suppliers should also be aware that CMS targets audits of medical necessity documentation based on two major factors: 1) the overall utilization of the product by Medicare beneficiaries (diabetic supplies, nebulizers, etc.), and 2) higher reimbursed items such as PMDs and oxygen. The bottom line is that CMS targets products that cost the Medicare program the most money. DME Supplier’s “business decisions” about documentation should be based on that knowledge.

So, how do you compete with other DME suppliers that do not require the same level of physician documentation that you request? Here are some tips:

- Verbally educate your physician referral sources about CMS requirement for medical necessity documentation evidenced by physician or other treating practitioner progress notes. Your sales representatives should be experts at this task.

- Use our materials to provide your physician referral sources with easy to understand written guidance about CMS medical necessity qualifying criteria and documentation requirements.

- Every DMEPOS jurisdiction contractor has a physician medical director that has created product level “physician to physician” letters explaining to your referral sources that it is CMS that is requiring this documentation; that it’s not your fault you have to ask for it. You can download these letters to provide to referral sources at your jurisdiction’s website.

- After providing the referral source with adequate documentation of CMS requirements, suggest to the resistant referral source that they may not want to be closely associated with a DME supplier that is not fully compliant with Medicare requirements.

- Finally, when you evaluate the relative value of referral source, consider how willing they are to provide the documentation you require. If you cannot get paid, and ultimately keep your claim dollars from a referral, then the referral source is not a “good” referral source no matter how many referrals they are in a position to send to your business.

5. You are not required to obtain the progress notes for DMEPOS products when CMS medical policies require a follow-up face to face evaluation be completed in a specific time frame for continued coverage (over-utilizing of diabetic supplies, oxygen, PAP products, etc.). However, you should document the day the physician follow-up evaluation occurred, either by
communication with the patient or the ordering/treating physician, and document that date in your HME software system, or the patient’s file.

If audited by CMS at a later date you can simply request the progress notes from that day’s physician visit. Keep in mind that when audited you have a very limited timeframe to produce this type of documentation. If you can provide your referral source with the exact date of the notes you need, you will be much more likely to receive them from the physician’s office in time to respond to the audit.

6. Supplier documentation is also important.

- Ensure that all DIFs for enteral and parenteral nutrition are updated when required according to the CMS medical policy.

- Do NOT automatically ship recurring supply products until you contact the patient (or they contact you) and you document in the patient file, or the patient record in your software system, the following elements: 1) the date and time of the contact, 2) the specific supplies being requested, and 3) that the patient/caregiver specifically states they have nearly exhausted their supply of the product.

- Maintain shipping logs (for 7 years) as proof of delivery for items that are shipped to a patient instead of delivered in person. Be aware that you may have to use the archive feature of your shipping software as it may not retain a log for 7 years without using the archive feature. Be sure to include the computer file containing this archive in the data that is regularly backed up on your computer system. It is not necessary to require a signature at the time of delivery for products that are shipped to a patient – the log created by your shipping software will suffice.

- Document a home evaluation for manual wheelchairs and power mobility devices. This can be done by physically assessing the home environment at the time of delivery or via an interview with the patient or caregiver if they take delivery of the item from your retail store.

Obtaining DWOs, CMNs and other documentation in a timely manner:

With few exceptions for products requiring a written order prior to delivery (see product level cheat sheets including TENS units, support surfaces, power mobility devices, wheelchair cushions, and seat lift mechanisms), CMS allows DMEPOS suppliers to dispense products based on a verbal or telephone order. That means that DME suppliers are faced with another “business decision” as to what they will deliver prior to receiving the CMN or detailed written order required to bill the claim. A few tips:

1. Never deliver oxygen before obtaining qualifying test results prior to delivery. These are typically sent via fax. Ask the referral source to fax the test data during the intake process. You can safely obtain the required CMN later, but you should ensure the test results qualify the patient for oxygen reimbursement prior to delivery. You are required to have a copy of the test results on file, so it makes sense to get them prior to delivery, when it can do you the most good.

2. Never deliver PAP equipment prior to obtaining a qualifying sleep study from a Medicare qualified sleep lab. See the product level cheat sheet for qualifying criteria. You can deliver the PAP equipment prior to obtaining the required detailed written order, but you should ensure that the patient meets the qualifying criteria, through an assessment of the sleep study, prior to delivering the equipment and supplies. CMS requires that you obtain either a CMN, or a physician’s order that includes a start of care date, patient name, and some defining characteristic for that patient such as an address, or Medicare number. In addition, a length of need is required on the
prescription when the item is a recurring supply or recurring rental. A typical prescription pad order does not include this level of detail. You may dispense on a verbal or telephone order, but you cannot bill the claim until you obtain a billable order (either a compliant detailed written order, or a CMN, as required by policy – see product level cheat sheets for more detail regarding the documentation required per product).

If you make the “business decision” to deliver certain products based on a verbal or telephone order in order to compete with other DME suppliers in your marketplace, you should have a tracking mechanism in place to obtain the CMN or detailed written order in a timely manner. Here are some tips for obtaining required documentation in a timely manner:

- Send the documentation form (CMN or detailed written order) to the ordering/treating physician (usually via fax) for completion within 24 to 48 hours of receiving the verbal or telephone order.

- If you do not receive the completed CMN or detailed written order back (again, typically via fax) from the ordering/treating physician within 7 days, call to remind them that you have sent it and need it back ASAP; re-fax the order if necessary.

- If you do not receive the completed CMN or detailed written order back (again, typically via fax) from the ordering/treating physician within 14 days re-print the form for hand delivery via your sales representative or courier. Instruct your sales representative or courier to let the physician’s office know that you will be returning to pick up the completed documentation within 48 hours of hand delivery. Typically the referral source will ensure that the documentation is ready if they know you will be making a specific trip back to their office to retrieve it.

- Remember, the DME supplier is permitted to fully complete the detailed written order form (based on information provided during the intake process) prior to sending it to the physician for a signature and signature date. Fully completed DWOs are often returned more quickly than those that require the physician’s office to fill in details such as length of need, diagnosis, and other blank fields.

**Physician Signatures**

Audit contractors are consistently denying reviewed claims when physician signatures on required order forms are illegible. As all medical providers are aware, physician’s signatures are almost always illegible. DME suppliers have a few different options available to them in order to comply with these requirements. These are detailed in the following MedLearn transmittal:


We recommend that you utilize physician order forms that require the ordering/treating physician to print their name below their signature, or HME Software system forms that include the typed physician name below the signature line. As an alternative, you can also acquire a signature log or physician attestation each time an order is placed (attestation must include the beneficiary information). Details about the content of an acceptable attestation or signature log are provided in the MedLearn transmittal linked above.

We believe a system generated form that includes the typed physician name below the signature line is the most practical and efficient method of meeting this requirement. If your HME software system vendor has not modified its order forms to meet this requirement (implemented in the spring of 2010) consider contacting the vendor to suggest that they re-format their order forms.
Diagnosis Coding

Many DMEPOS items require that the claim include a specific patient diagnosis in order to meet Medicare medical necessity criteria. Typically, a DME supplier will be provided or will seek that specific diagnosis from the referral source during the intake process. Some will even include a qualifying diagnosis on the detailed written order that they send to the ordering/treating physician to sign and date. With this in mind, here are some important tips to remember about diagnosis coding:

- The DME supplier is permitted to receive a narrative diagnosis from the referral source (Congestive heart failure) and translate that to a diagnosis code (428) for claim filing purposes.

- It is extremely important that DME suppliers are aware that diagnosis codes included on a signed physician order do NOT, alone, justify medical necessity. There must also be proof of that diagnosis in the patient’s medical record — typically found in physician progress notes, H&P documents, and/or consulting physician reports. For this reason, we discourage DME suppliers from “coaching” a qualified diagnosis from the referral source.

- In all instances, a diagnosis must be coded to the highest level of specificity available for that diagnosis code. DME suppliers are encouraged to 1) keep diagnosis code databases up-to-date in their software system, and 2) consult current coding manuals or online coding databases to aid in coding a diagnosis to the highest level of specificity. We recommend that DME suppliers attempt to minimize the use of NOS (not otherwise specified) or NEC (not elsewhere classified) diagnosis codes when possible.

CMS Audits / Audit Avoidance

CMS is currently employing a variety of audit processes to reduce fraudulent or improperly paid claims. Some of these audit contractors are paid based on the amount of money they recoup for the Medicare program (the bounty hunter model); some identify what they believe to be improper payments in order to justify the millions of dollars they are paid by the government as an outsourced contractor.

CERT audits are random in nature — using what can best be described as a survey model to identify what may be improper payments — in order to assess the effectiveness of the DME claim contractor (your local DMEPOS jurisdiction contractor that processes your claims for payment.) A CERT audit typically includes a request for supporting documentation on a limited number of claims at any one time. Payments denied based on a CERT audit must be appealed to the local contractor.

Cert auditors are typically looking for claims paid in error when there was a lack of documentation on file (the documentation a supplier claims they have in the patient’s record when using the KX modifier); diagnosis codes that are not supported by the physician record; and claims filed in the absence of documentation that a patient had physician follow-ups as required by some product medical policies.

ZPIC and RAC audits target suppliers based on database analysis and data mining, and can effectively paralyze a targeted company’s current business operations by requesting supporting documentation on a hundred or more claims in a single request. They can also result in a DME supplier being placed on pre-payment review, which can paralyze a company’s cash flow. Here are some common issues that may trigger audits:

- Large number of duplicate claim denials — this signals to audit contractors that you may not understand the coverage criteria for DMEPOS products. The definition of insanity is repeating the same thing and expecting a different result. Do not resubmit denied claims until you have addressed the reason the claim was denied.
• Significant numbers of improperly coded claims submitted for payment / consistent, improper use of modifiers – again this signals to the audit contractor that you may not understand the DMEPOS claims filing process, or the specific requirements for certain product codes.

• Frequent "date of death proceeds date of service" denials – this signals to the audit contractors that you do not follow up with patients receiving capped rental items, prior to submitting a claim, to ensure that they are still using the equipment. A practical way of reducing these types of denials is to call each current patient receiving capped rental equipment every three months to ask if they are still using the item. You are not required to document this call, but you may wish to include it in your HME system software patient notes.

• Unbundling of equipment – many HCPCS codes include component parts and should be used for the initial claim. For instance, the code E0260 includes a bed, mattress and rails. Codes also separately exist for rails and mattresses, etc., but these codes many only be billed when replacing that specific part on a rental item that has capped and is owned by the patient. Often (but not always) the description for a component part will include the phrase “replacement only.” It is important for DME suppliers to understand what is included in the codes they bill, and to avoid unbundling when submitting claims for an initial delivery of a DMEPOS item.

• Duplicate payments to home health agencies, hospitals, skilled nursing facilities and the DME supplier – the various parts of CMS are now communicating with each other (at least from a data mining perspective), and contractors are identifying when payments are improperly made based on the products provided and the actual “place of service” (where the patient is residing) for a given date of service on a claim. Always remind patients and caregivers to notify you if the patient enters a hospital or SNF, or comes under the care of a home health nursing agency if they are receiving supplies bundled into the HHNA services payment. In addition, contacting patients routinely as suggested in the guidance on avoiding “date of death proceeds date of service” denials will help reduce duplicate payments that may trigger an audit.

• An unusual increase in claims in a short period of time— for instance an increase from $50K in claims a month to $500K claims in a month over the course of a very short period of time may cause audit contractors to suspect fraud and trigger an investigation.

• An unusual increase in claims for a specific product in a short period of time – for instance an increase in PMD claims from 10 a month to 100 a month in a very short period of time may cause audit contractors to suspect fraud and trigger an investigation.

• An unusually high number of claims from a DME supplier for a specific product code that exceeds normal utilization patterns for Medicare beneficiaries in the community served by the DME supplier. Again, this may cause audit contractors to suspect fraud and trigger an investigation.

• Complaints to CMS from physicians or other health care providers that patients are coming to them seeking a prescription for a product advertised by a specific DME supplier. Medicare believes that the physician or other qualified health care provider should be the party initiating the request for covered DMEPOS items.

**Important:** Always consult the relevant medical policy before responding to any audit request to ensure that you are cognizant of the documentation that is required for the specific product(s) included in the audit request.

**Common Benchmarks**

Benchmarks can be useful to assist DME owners and managers in evaluating their processes and making comparisons to other DME companies they compete with. But keep in mind, these are just averages – your metrics may vary depending on product specialty, product mix, payer mix and what is
included in the job duties of specific personnel. Here are some common benchmarks that DME suppliers can use to measure themselves against the average DME supplier, and best practices:

**Revenue:** The average single location DME generates $1.2 to $1.5 in revenue per year. This is projected to increase to $3 million per year as the industry experiences more consolidation from DME providers exiting the business due to competitive bidding and other reimbursement pressure.

New DME providers can expect to generate $60-$80K in revenue per month their first year, increasing to $100-$120K per month in the second year.

**Revenue to FTE ratio:** This is a productivity measure that indicates how much revenue is generated per full time employee. The higher the number, the more productive and efficient your DME processes are judged to be. The average is $110-$120K per full time employee. The ambitious DME provider who wants to remain profitable in the current environment should set a revenue goal of $130K-$150K per full time employee. Productivity can be best improved by automating processes to the extent possible. Typically this requires an investment in technology such as bar code scanners, document imaging, routing software or GPS tools, and a well-functioning and modern HME software system.

**DSO:** This metric represents the average amount of time (in days) that it takes to collect receivables once the product has been provided to the patient and the insurance claim process begins. The formula is as follows:

1. Net Revenue / days in period you are assessing = average days sales (the amount of revenue, on average, that you generate in one day).
2. Total Net AR / average days sales = DSO

The average DSO in the DME industry is approximately 70 days. It will be lower (approx. 55 days) if your payer mix is higher in the area of Medicare; higher if your payer mix leans more toward private insurance payers. Product mix also impacts DSO. Companies that specialize in power mobility and complex rehab will have a higher DSO than companies that offer a full line of DME products or specialize in respiratory products. An overall DSO that is over 90 days indicates that reimbursement processes need to be improved.

**Documentation Turnaround:** Insurance payers, including CMS, require that you have the documentation called for in the medical policy prior to submitting a claim. Therefore, it is important, for cash flow purposes, that you obtain the documentation in a timely manner. 95% of your documentation should be received in less than 30 days from the time the product was provided.

**AR Aging:** This metric is useful to determine if you are collecting revenue in a timely manner. Keep in mind that the older your revenue is, the less likely you are to collect it. The percentage of your revenue in various aging “buckets” should be as follows:

- 30 days or less: 35-40%
- 31-60 days: 25-30%
- 61-90 days: 15-20%
- 91-120 days: 10-15%
- Over 120 days: 5-10%

The most important metric to assess here is the entire over 90 day and up metric. In no case should your total AR that is over 90 days represent more than 25% of the AR as a whole.

**Denial Rate:** The average DME has a denial rate just over 10%. Your target should be 6% or less.
**Billing Staff:** For the purpose of this metric a billing staff member is defined as an employee who processes claims, addresses/corrects denials, and works the accounts receivables to collect revenue. They should spend 20% of their time processing and sending claims, and 80% of their time working denials and aging reports. If this definition accurately describes your billing staff member’s role you can expect to require one biller for every $500K-$600K in revenue generated by your company.

**Average Collection Timeframes:** Here is what you can expect for collection timeframes from the date of submission of a claim to various types of payers:

- **Medicare:** 21 days from the date of electronic submission
- **Medicaid:** varies by state 21 to 30 days from date of electronic submission
- **Commercial insurance filed via paper claim:** 45 days from date of mailing
- **Commercial insurance filed via electronic claim:** 30 days from submission
- **Private Pay sent via invoice/statement:** 30 days from receipt

**Daily / Weekly / Monthly Checklists**

It can be useful to understand what reimbursement processes should be completed on a daily, weekly, or monthly basis. Here are some basic suggestions:

**Daily: Intake and Documentation**

- Order intake / insurance verification / same or similar checks
- Initial prior authorization requests
- Data entry / delivery ticket preparation
- Confirm orders with tickets returned signed from the previous day’s deliveries
- Prepare and send new documentation requests
- Receive, QA, and enter documentation that has been returned into billing system
- System back up unless automated - automated off-site back-up is ideal

**Weekly: Intake and Documentation**

- Run and work expiring CMN, physician order, and prior authorization reports
- Prepare / send renewal documentation requests
- Run and work unconfirmed orders report
- Follow-up on unconfirmed deliveries (non-returned tickets)
- Run and work documentation tracking reports
- Follow-up on documentation still pending in accordance with defined timelines

**Daily: Billing and Collections**

- Run electronic billing process – all payers should be billed electronically, as available
- Post cash as payments are received
☐ Work denials as they are received / hold recurring claims for products denied until denial reason is corrected

☐ Work accounts receivables – over 90 days and high dollar down – work entire account, not just specific items or dates of service, when working AR (including private pay accounts)

☐ QA and review system entry of documentation that has been received by intake staff

**Weekly: Billing and Collections**

☐ Run electronic billing (if not billing daily due to less than $30K in monthly revenue)

☐ Print and mail paper claims as needed when electronic filing is not possible

☐ Generate secondary claims for those that do not crossover, and mail to payers with necessary EOBs

☐ Review EMC transmission error reports and make necessary corrections (review as often as you bill)

**Monthly:**

☐ Generate and review month end and executive reports

☐ Generate and mail private pay and commercial account bills or statements

☐ Generate and mail collection / dunning letters

**Conclusion**

We hope this general DMEPOS reimbursement guidance documents proves useful to your business. Clients of Domos HME Consulting and Billing should not hesitate to call us with any questions about any aspect of the reimbursement process. We are here to help.

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