

## AAH Best Practices and Mobility Documentation

May 2008

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## Roadmap

- History
- Understanding Documentation
  - MAE NCD
  - Key Concepts
- Audits
- The WHY of MR...CMS Requirements

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## Policy History

- Original National Policy
  - Bed or Chair Confined – ALL
  - Unable to self-propel - PWC, POV
  - Specialist requirement, etc. – POV
- Interpretation of “bed or chair confined”
  - Non-ambulatory vs. Functionally non-ambulatory
  - Limited ambulation
- Dec 2004 Clarification – non-ambulatory
- May 2005 –Mobility Assistive Equipment (MAE) NCD

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## History Continued

- October 2005 - Interim Final Rule
  - Visit, F2F & 7-element order in 30 days
- June 2006 – Final Rule
  - Visit, F2F & 7-element order in 45 days
- November 2006
  - New HCPCS codes
  - PMD LCD

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MAE  
NCD

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## NCD 280.3 MAE, A - General

- ...addresses numerous items that it terms “mobility assistive equipment” (MAE) and includes within that category canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters

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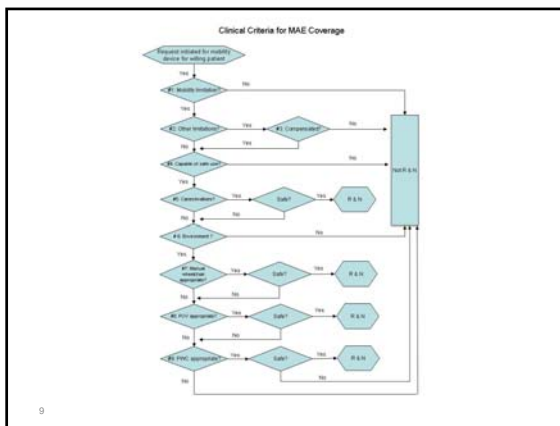
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## NCD 280.3 MAE, B - Indications

- ...the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home.
- Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.
- Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
- These questions correspond to the numbered decision points on the accompanying flow chart.
- In individual cases where the beneficiary's condition clearly and unambiguously precludes the reasonable use of a device, it is not necessary to undertake a trial of that device for that beneficiary.

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## Key Concept #1

- What is required on the front end is needed but, by itself, is insufficient for an Audit.
- Claim Submission
  - Examples: Rx, Del. Slip, DIF/CMN, Home eval., Etc.
- Audit
  - Above PLUS Medical Record information showing that LCD criteria are met.

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## Key Concept #2

- Sequence counts
  - OK
    - Visit, F2F, 7-element order, DPD
    - F2F, Visit, 7-element order, DPD
  - NOT
    - Visit, 7-element order, F2F, DPD

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Key Concept #3

# Information NOT Documents

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## Documents

- H&P
- Discharge Summaries
- Progress Notes
- Therapy Reports
- Etc.



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## Example

- Document - H&P
- Information -
  - 68 yo WM hx of CHF, DJD, MI, DM...
  - LE str +2/5
  - Balance poor, gait unsteady
  - LAB FBS 300
  - O2 SAT 87%

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## Why Not Documents??


- PRA
  - Paperwork reduction Act
- Electronic Claim Submission



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## What Are We To Do?

- Think Differently!
- Learn the LCD requirements
- Ask for Information (FROM THE MEDICAL RECORD) that demonstrates that the criteria are met



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## You Already Think This Way...

# ABN

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## What Do You Need To...

- Submit a claim
  - 7-element order
  - F2F
  - DPD
- Deal with an audit
  - Above PLUS corroborative information from the Medical Record about “Visit” and R&N for all options and accessories

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## Audits

- CERT Error Rate
- Data Driven
- INFORMATION, not documents



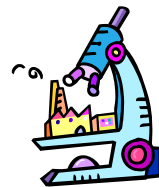
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## Audits

- Pre-pay and Post-pay
- Supplier Specific or Widespread
- CDR
- OIG
- CERT
- RAC



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## Survival

- Know the policy
- Know the Manuals
- Work with your referral sources
- Access to medical information
- Be specific
- Respond



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## Non-LCD

- Repairs
  - Sept 2003
- Upgrades
  - May 2007 Bulletin
  - Change from “ordered” to “medically necessary”



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#### PIM 1.1

- The CMS' national objectives and goals as they relate to medical review are as follows:
  - 1) Increase the effectiveness of medical review payment safeguard activities;
  - 2) Exercise accurate and defensible decision making on medical review of claims; and
  - 3) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse.

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#### PIM 1.2

- The MR program is designed to promote a structured approach in the interpretation and implementation of Medicare policy.

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#### PIM 3 MR 4.5 Complex Medical Review

- Complex medical review involves the application of clinical judgment by a licensed medical professional in order to evaluate medical records
- Complex medical review determinations require a licensed medical professional to make a clinical judgment about whether a service is covered, and is reasonable and necessary.

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#### PIM 5.2 Orders

- Orders
  - Verbal (dispensing)
  - Written
    - WCVO
    - WOPD
    - CMN

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#### PIM 5.3 CMN

- CMN
  - Section A – supplier
  - Section B – physician
  - Section C – supplier
  - Section D – physician

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### PIM 5.7 Doc for Med. Nec.

- For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).

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### 5.7 Continued 2

- If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record.
- However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier.
- There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

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### 5.7 Continued 3

- The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

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### 5.7 Continued 4

- The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MAC or DME PSC.
- However, the DME MAC or DME PSC may request this information in selected cases.
- If the DME MAC or DME PSC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

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### PIM 5.8 Supplier Doc

- Before submitting a claim to the DME MAC the supplier must have on file
  - a dispensing order,
  - the written order,
  - the CMN (if applicable),
  - the DIF (if applicable),
  - information from the treating physician concerning the patient's diagnosis (if an ICD-9-CM code is required on the claim), and
  - any information required for the use of specific modifiers or attestation statements as defined in certain policies.

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### 5.8 Continued 2

- The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criterion for an item has been met.
- If the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained

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## PIM 5.9.2 Evidence Medical Necessity - PMDs

- The physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) must conduct a face-to-face examination of the beneficiary and write a written order for the power mobility device (PMD).

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## Cont. 2

- The face-to-face examination requirement does not apply when only accessories for power mobility devices are being ordered, nor does it apply for the ordering of replacement PMDs.
- A replacement PMD would be the same device as previously ordered. For instance, if a beneficiary has a POV but would like to replace the POV with a power wheelchair, then a face-to-face examination would need to be conducted.

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## Cont. 3

- The written order must include the beneficiary's name; the date of the face-to-face examination; the diagnoses and conditions that the PMD is expected to modify; a description of the item; the length of need; the physician or treating practitioner's signature; and the date the order is written.
- The written order for the PMD must be in writing and signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination. The face-to-face examination requirement does not apply when only accessories for power mobility devices are being ordered.

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## Cont. 4

- The physician or treating practitioner must submit a written order for the PMD and the report of the face-to-face examination to the supplier. These documents must be received by the supplier within 45 days after the face-to-face examination. For those instances of a recently hospitalized beneficiary, the written order and report of the face-to-face examination must be received by the supplier within 45 days after the date of discharge from the hospital.

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## Cont. 5

- Prior to dispensing a PMD, the DME supplier must obtain from the physician or treating practitioner who performed the face-to-face examination the written order accompanied by supporting documentation of the beneficiary's need for the PMD in the home.
- Pertinent parts from the documentation of the beneficiary's PMD evaluation may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans.

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## Cont. 6

- The physician or treating practitioner should select only those parts of the medical record that clearly demonstrate medical necessity for the PMD. The parts of the medical record selected should be sufficient to delineate the history of events that led to the request for the PMD; identify the mobility deficits to be corrected by the PMD; and document that other treatments do not obviate the need for the PMD, that the beneficiary lives in an environment that supports the use of the PMD and that the beneficiary or caregiver is capable of operating the PMD.

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Cont. 7

- In most cases, the information recorded at the face-to-face examination will be sufficient. However, there may be some cases where the physician or treating practitioner has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record.
- In this instance, those previous notes would also be needed.

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