cc fyi: Diana
Chris
Jennifer

NAMES

National Association for
Medical Equipment Services

December 19, 1995

Honorable Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

Dear Carol:

Thanks so much for meeting with Walt Patterson and I last Friday morning regarding legislative and regulatory concerns pertaining to the home medical equipment services industry. I really appreciated your valuable time and that of your assistant, Diana, as well as your reading the critical background material left with you.

As I shared, we are greatly dismayed at the initial assault on the industry from Congressional and Administrative sources. Though we represent a fraction of the industry, we are trying to be the most conscientious and respectable group solely dedicated to the best access and quality of home medical equipment services in the industry. We have a Code of Conduct and Ethics Committee to push for the best standards in the industry. We have worked with the FBI and Office of Inspector General, DHHS, when and where possible. As shared with you, we testified at the HCFA "listening session" and made sound suggestions on how best to address fraud and abuse. We don't like it any more than the President, the Administration and Congress.

We are pleased that saner minds are prevailing so that the Medicare cuts may not be as drastic as originally, unfortunately, put forward by Bruce Vladeck and HCFA in August, 1995, and picked up by Senator Simpson. All was based on faulty analysis by HCFA of VA data. Note the Guy King report shared with you.

We support the President in wanting to cut the rate of growth of Medicare and Medicaid to a more reasonable level. That is why we have supported cuts in excess of 8% from 14% projected for our industry down to a more manageable 6% to 7% for each of the next 7 years. But we would like the Administration's position to be based on sound policy and analysis.

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Specifically, of primary importance to our constituents are the reduction from the proposed 20% cuts phasing in large reductions from 1996 to 2002 to more reasonable and appropriate cuts of 10% for oxygen equipment and services. This is still greater than our proportionate share. We also need to eliminate competitive bidding that will not result in the best access and quality for Medicare beneficiaries. Competitive bidding will potentially eliminate our small business industry. And we need to open up the 7-year freeze on the Consumer Price Index for all DME and greatly appreciate the President's position on this.

Again, thanks for your thoughtful consideration. May you have an enjoyable holiday and a healthy and prosperous New Year. See you in early 1996.

Sincerely,

Bill

William D. Coughlan, CAE
President and CEO

Meeting with Carol Rasco/Walt Patterson
The White House
December 15, 1995

Legislative

1. Oxygen Cuts 20% - 30% cuts - Pres plan = Cong
   met w/ Bruce
   VA too high
   Guy King
   Harkin
   NAMES represents minority of suppliers
   change coding system
2. Competitive Bidding
3. Freeze on CPI
   We have none?

Regulatory

1. Inherent Reasonableness of Oxygen and HME
2. Competitive Bidding
3. Certificates of Medical Necessity - Industry + OMB met last wk; praises Katzen
4. Fraud and Abuse
5. Business and Services Standard

NAMES
National Association for Medical Equipment Services

Budget Reconciliation

We have offered Congress our proportionate dollar share in Medicare cuts.

Congress recently passed the 1995 Budget Reconciliation Act, which contains several provisions which would greatly affect the HME services industry. The home medical equipment (HME) services and rehab/assistive technology industry has worked with Congress throughout the budget process to offer our fair share of cuts.

- **The proposed Medicare cuts would devastate the HME services industry as well as reap undue harm on Medicare beneficiaries!**

- The home oxygen therapy industry is one of the **most cost-effective** Medicare benefits. Oxygen therapy has **strict utilization controls** including a 20 percent co-pay, a physician prescription and an arterial blood gas test. Oxygen therapy allows beneficiaries to stay in the home where they prefer to be.

- We understand the difficult challenge facing Congress. For this reason, the HME services industry has presented a proportionate cuts proposal for Medicare for our industry. The industry wants to work with Congress. However, the magnitude of the **proposed cuts** would be **devastating** and would result in severe losses to the HME services industry and to the Medicare beneficiaries who receive our services, 24 hours a day, 7 days a week.

- NAMES has expressed to Congress the following concerns:

  -- The proposed 20 percent reduction in the Medicare reimbursement for home oxygen therapy must be reduced to the industry's proportionate share. The industry is prepared to **accept** up to a **10 percent** cut for the home oxygen benefit.

  -- Any future **competitive bidding** proposal for HME should **be rejected** by Congress.

  - working w/ blue dogs

  -- The **seven-year CPI freeze for all HME is excessive** on top of the proposed oxygen reimbursement cut, since this industry has received 18 Medicare reimbursement cuts in the past nine years.

  -- Congress should adopt performance standards for home oxygen therapy, as suggested in testimony last year by the HHS Inspector General.

- NAMES wants to work with Congress to provide savings for Medicare. We also have **designed**, through our Coalition of Health Associations United Against Fraud & Abuse, a **proposal** to help **rid** the health care industry of any **fraud**. This additional proposal will also save our country billions of dollars. Some provisions have already been included in the budget package.

In Summer, (accept) ... Comp bidding demo in S[illegible]
Need sides of care

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December 1995

Payments for Home Oxygen Equipment and Supplies
by
the Medicare Program and Veterans Administration

Prepared by:
Roland E. King, FSA, MAAA

Background and Overview:

Proposed legislation to reform the Medicare program includes substantial reductions in Medicare payments for home oxygen equipment and supplies. Legislation proposed in the Senate provides for a 40 percent reduction in Medicare payment rates and legislation proposed in the House of Representatives provides for a 20 percent reduction in Medicare payment rates. In addition, the Health Care Financing Administration (HCFA) has proposed reductions in Medicare payment rates ranging from 7 percent to 43 percent based on the inherent reasonableness provisions of the Medicare statute.

These proposed reductions in payment rates appear to be based on two factors: (1) data published by the Veterans Administration (VA) indicating that payment for home oxygen by the VA is substantially lower than payments by the Medicare Program, and (2) a shift in modality observed by HCFA in the provision of home oxygen services and supplies that has occurred since the payment rates were determined under the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). King Associates was engaged by the Davidson Colling Group to review and comment on the technical soundness of these findings.

Executive Summary:

To estimate monthly VA payments for home oxygen, I examined twelve VA home oxygen contracts (previously selected by the Office of the Inspector General) and used the itemized schedule of payment rates in these contracts to construct the monthly cost to the VA for a patient using either a concentrator or liquid oxygen equipment. These estimates were constructed under low utilization and high utilization assumptions, described in more detail in the section describing the analysis of the VA home oxygen contracts.

Using the Medicare based distribution, contained in HCFA's 1994 BMAD file, of 84 percent concentrator patients and 16 percent liquid oxygen patients, under the high utilization assumption, the 75th percentile of monthly costs was $370.79 and the 25th percentile of monthly costs was $214.50. The median monthly cost for the twelve contracts was $336.81. Under the low utilization assumption, the 75th percentile of monthly costs was $298.19 and the 25th percentile of monthly costs was $176.90. The median monthly cost for the twelve contracts was $270.10.

Data published by the VA is much lower than the figures indicated above, but I have determined that the VA data is not credible based on a lack of face validity and simple spot checks. These

spot checks are described in more detail in the section discussing the consistency of the VA data with the results of this study.

I understand that the average monthly Medicare payment for oxygen and the associated equipment and supplies is approximately $280 for stationary equipment and $45 for portable equipment, for a total of $325 for a patient using both stationary and portable equipment. While it is possible that the twelve contracts selected by the OIG may not be representative of all VA home oxygen contracts, this analysis suggests that the VA and Medicare payments for home oxygen therapy are substantially similar.

I also examined HCFA's analysis of the modality shift that had occurred since the payment rates for home oxygen had been established in 1987. HCFA's analysis of the modality shift was flawed. It only examined the change in the percent of patients using concentrators, thereby concluding that a shift to a less expensive modality had occurred. When all three modalities are examined, the percent of patients using the least expensive modality (gaseous oxygen) has declined and the percent of patients using the most expensive modality (liquid oxygen) has increased. Home oxygen contractors have absorbed the cost of this shift under HCFA's modality neutral payment method.

Different VA and HCFA Payment Methods for Oxygen Equipment and Supplies:

HCFA and the VA use substantially different payment methods for oxygen equipment and supplies which make direct comparisons difficult.

Summary of HCFA Payment Method:

HCFA pays a flat monthly rate for stationary oxygen equipment which includes payment for all of the ancillary supplies and oxygen consumed with that equipment. This payment is the same regardless of the type of stationary equipment used and regardless of the amount of oxygen supplied. If portable equipment is needed in addition to the stationary equipment, an additional flat monthly rate is paid for the portable equipment. Payment for the cost of oxygen consumed by the portable equipment is included in the stationary equipment payment amount.

Summary of VA Payment Method:

The VA pays for oxygen equipment and supplies on the basis of an itemized payment schedule established by contract at each local site. The VA establishes separate payment rates for each different type of stationary equipment, each different type of portable equipment, and each separate piece of ancillary equipment. In addition the VA pays separately for oxygen by the contents, with different payment rates for gaseous (per cylinder) and liquid (per pound) oxygen.

Comparison of VA and Medicare Payments for Home Oxygen:

VA payments for home oxygen services and supplies cannot be directly compared to Medicare payments for home oxygen equipment and supplies because of the differences in the two payment methods. Moreover, estimation of the total monthly VA payments for oxygen and oxygen supplies and equipment is extremely complex because of the fragmented way that VA pays for oxygen and associated supplies and equipment.

For example, a comparison of the VA's monthly payments for oxygen concentrators with HCFA's flat monthly payment for fixed equipment would not be valid because the VA monthly rate covers only the oxygen concentrator itself, while HCFA's monthly rate covers the oxygen concentrator and all the ancillary supplies and equipment. If liquid oxygen (a much more expensive piece of stationary equipment than an oxygen concentrator) is used as the stationary equipment, HCFA's monthly rate covers not only the equipment but all of the liquid oxygen consumed through that equipment.

Analysis of VA Home Oxygen Contracts:

Twelve VA home oxygen contracts were analyzed to determine the monthly payments made by the VA for home oxygen. The twelve VA contracts used in this analysis were selected for study by the Office of the Inspector General (OIG). I understand the OIG did not pursue this study to its conclusion when its preliminary findings suggested that VA and Medicare payments for home oxygen equipment and supplies were substantially the same.

In order to convert the VA itemized payment schedule costs to monthly costs, it was necessary to make assumptions regarding the monthly utilization of oxygen. The low assumption is ten portable cylinders per month for those patients using concentrators and 300 pounds of oxygen per month for those patients using liquid oxygen. The high utilization assumption is 15 portable cylinders of oxygen per month for those patients using concentrators and 350 pounds of oxygen per month for those patients using liquid oxygen. The high utilization assumption represents about 56 hours per month (slightly less than two hours per day) of portable oxygen utilization and the low utilization assumption represents about 37 hours per month (slightly more than one hour per day) of portable oxygen utilization for the average patient.

Using the Medicare based distribution of 84 percent concentrator patients and 16 percent liquid oxygen patients, under the high utilization assumption, the 75th percentile of monthly costs was $370.79 and the 25th percentile of monthly costs was $214.50. The median monthly cost for the twelve contracts was $336.81. Under the low utilization assumption, the 75th percentile of monthly costs was $298.19 and the 25th percentile of monthly costs was $176.90. The median monthly cost for the twelve contracts was $270.10. The table below summarizes the development of these estimates under the low utilization and high utilization scenarios.

Monthly VA Home Oxygen Costs

Percent	Low Utilization			High Utilization		
	Concentrator	Liquid	Weighted	Concentrator	Liquid	Weighted
25th	$175.83	$182.50	$176.90	$215.83	$207.50	$214.50
50th	262.50	310.00	270.10	335.25	345.00	336.81
75th	280.50	391.08	298.19	357.50	440.58	370.79

Explanation for Discrepancy with VA Data:

The monthly payment amounts displayed in the table above are significantly higher than the data displayed in the "NATIONAL HOME OXYGEN PROGRAM FY94 Cost Review" published May 1995 by the National Center for Cost Containment, Department of Veteran Affairs, Milwaukee, WI. What is the explanation for this large discrepancy?

An examination of the summary cost data on page VII of this document reveals such great variation that it does not appear to be plausible on its face. For example, the reported monthly cost for patients using rented concentrators varies from a minimum of $14.24 to a maximum of $465.00; the monthly cost for patients using rented cylinders varies from a minimum of $6.00 to a maximum of $252.00; the monthly cost for rented liquid varies from a minimum of $20.00 to a maximum of $1,392. It does not seem plausible, even with market differences, that the variation in payment can be this great.

In order to ascertain if this questionable data was flawed, I performed a rudimentary spot check of the data. I obtained copies of the contracts for two of the sites reporting low costs and compared the provisions of the actual contracts with the data reported. The results of this spot check are as follows:

> For the Buffalo, NY site, the VA report (page 35) indicates that the total monthly payment for a full range of oxygen supplies and services for a concentrator patient is $14.24 . However, the contract for the Buffalo site indicates a monthly fee of $51.24 for concentrator rental alone. Additional monthly fees include $13.45 for each portable E-cylinder or $12.75 for D-cylinders.
>
> For the Cheyenne, WY site, the VA report (page 49) indicates that the total monthly payment for a full range of oxygen supplies and services for a concentrator patient is $85.00. However, the contract indicates a monthly rental fee of $85.00 for concentrator rental alone. Additional costs itemized in the contract include a $14.00 delivery and set-up fee, a $16.00 monthly fee for service visits, a $4.25 fee for each portable E-tank refill, and a $9.25 fee for each H-tank refill.

Given the lack of face validity of the data and its failure to pass even a rudimentary spot check, I have concluded that the VA data is not credible. In fact, the VA's own report states on page VII that the VA "recognizes that some facilities may have had difficulty determining their costs."

Analysis of Modality Shift:

I examined HCFA's analysis of the modality shift that had occurred since the payment rates for home oxygen had been established in 1987. I used the same BMAD data that HCFA used in its analysis. Since the percent of fixed equipment using oxygen concentrators (a less expensive modality) had increased, HCFA had conjectured that the percent of liquid oxygen (the most expensive modality) had decreased.

A more careful analysis which examines all three modalities (concentrators, gaseous oxygen, and liquid oxygen) reveals that the percentage of liquid oxygen has increased, even as the percent of concentrators has increased. These increases in the use of concentrators and liquid oxygen have taken place at the expense of gaseous oxygen (the least expensive modality). Thus, an analysis of the modality shift shows that there has been a shift to the higher cost modalities rather than to the lower cost modality. Under HCFA's modality neutral payment system, oxygen suppliers absorbed the increased cost of this shift in technology.

The table below indicates how HCFA arrived at the erroneous conclusion that a shift to a less costly modality had occurred. The table also shows that HCFA's modality shift, though incomplete, is consistent with a complete analysis, but the HCFA analysis does not capture the shift to liquid oxygen, the most expensive of the three modalities.

Comparison of Modality Shift

	HCFA Analysis		Complete Analysis	
Year	1987	1993	1986	1994
Concentrator	68.2%	87.13%	66.4%	83.2%
Total, liquid & gaseous	31.8	12.87	33.6	16.8
Gaseous Oxygen	NA	NA	22.1	1.2
Liquid Oxygen	NA	NA	11.5	15.6

Conclusion:

My analysis of the twelve VA contracts selected by the OIG, review of the VA's published report "NATIONAL HOME OXYGEN PROGRAM FY94 Cost Review" and analysis of the modality shift suggest that (1) the VA monthly payment for home oxygen is essentially the same as the monthly payment by Medicare for home oxygen and oxygen equipment and supplies, (2) the VA data which seems to contradict this conclusion is not credible and (3) since the Medicare monthly payment rates for home oxygen were determined in 1987, there has been a shift to the more expensive modalities (oxygen concentrators and liquid oxygen), and away from the least expensive modality (gaseous oxygen).

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Competitive Bidding

Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access to HME for Americans.

Background

Competitive bidding has been proposed over the past several years as a helpful solution to problems in the Medicare program.

In 1993, the Clinton Administration submitted to Congress proposed legislation to reform the nation's health care system which included a provision that would have implemented competitive bidding.

In 1994, Congress decided that competitive bidding was **not** a good solution and did not provide quality health care for consumers.

In 1995, the House Budget Committee in its draft budget recommendations proposed competitive bidding for oxygen therapy and parenteral and enteral therapy.

Status

Competitive bidding under the Medicare program

Competitive bidding is a process whereby a home medical equipment (HME) service provider or rehab/assistive technology provider in a designated area submits a bid in hopes of winning **all** of the business in that designated area. Competitive bidding is synonymous with a "winner takes all" scenario.

Competitive bidding is anti-small business

It is difficult to design and administer any competitive bidding process without damaging the market. A winning bid awarded solely to one provider within a given service area would drive many small companies out of business, creating a considerably reduced level of competition.

Competitive bidding has been tried with the Medicaid program

Competitive bidding for certain selected HME items has been tried or considered and subsequently abandoned in a number of states. States found competitive bidding to impair freedom of choice for recipients, to render the States incapable of utilizing the expertise of all vendors, and to impede competition and access. For example:

- Ohio Medicaid officials concluded that competitive bidding was unworkable after issuing a request for purchase.

continued...

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June 1995

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National Association for Medical Equipment Services

Competitive Bidding – page 2

- Montana abandoned competitive bidding in its Medicaid program because the program was found to deny access to beneficiaries and impair the ability of the State to tap the expertise of all providers. Abandoning competitive bidding has resulted in greater access to care and freedom of choice for recipients.

- South Dakota backed away from a decision to implement competitive bidding in 1993 after deciding it could reduce Medicaid costs in other, more effective, ways.

Competitive bidding also has worked poorly for both the Defense Department and the Veterans Administration (VA), where it has been employed on a large scale similar to what Medicare may require. VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA contract winners. The Medicare program should expect similar, if not greater, problems in access and quality given the lack of standards for HME services under Medicare. In monitoring the provision of services under competitive bidding contracts in a number of states, the VA has found many providers to have limited knowledge or expertise in home oxygen and other HME items. Areas where such limitations exist include: quality of equipment, appropriateness of equipment, differences between various types of equipment, safety features and current pricing schemes.

Position

Competitive bidding hurts consumers

Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access to HME for Americans. Such a radical restructuring of how HME is provided would jeopardize the quality of HME services. In fact, in instances where competitive bidding has already been attempted, some providers have submitted unreasonably low bids to win the contract, only to find they could not cover the costs of providing the services. They thus have been forced to cut corners, with devastating results.

Recommendation

Competitive bidding for HME services of any type must not be included in any legislation. It has been tried and found not to provide the quality and scope of expected services or the anticipated program savings.

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June 1995

MEMORANDUM - December 14, 1995

RE: Certificates of Medical Necessity for Durable Medical Equipment - Revision Update

****

Background: Certificates of Medical Necessity (CMNs) are documents for collecting information to determine if the beneficiary's condition meets the Medicare policy for "medically necessary" equipment when a physician orders a covered item of home medical equipment (HME). The document also serves the program as part of the utilization control process and as the memorialization of the physician-supplier-carrier interaction.

Beginning in 1993 and extending through 1995, due to statutory changes, HCFA and the newly created Durable Medical Equipment Regional Carriers (DMERCs) have been in the process of revising and updating the CMNs. The revisions proposed as final in mid-1995 were not acceptable to the HME industry or physicians due to the increased paperwork burden and undefined rationale for the collection of non-medical necessity information on the forms. The National Association for Medical Equipment Services (NAMES), the American Society for Internal Medicine (ASIM) and the American Medical Association (AMA) met with the Office of Management and Budget (OMB) on September 29, 1995, and requested the OMB intervene and require HCFA to submit the forms to a Paperwork Reduction Act (PRA) Review. This request was subsequently supported by a coalition of HME industry and physician representatives. OMB directed HCFA to submit the forms as per the PRA requirements. Comments were submitted by the HME industry and physician groups and a meeting to exchange comments was conducted on November 29, 1995.

Current Status: NAMES and other industry and physician groups met again on December 8, 1995, with HCFA and OMB to receive HCFA's responses to the questions left with the agency and to obtain some insight into the agency's intentions regarding CMN revisions. HCFA has been given until December 19, 1995, to complete its final revisions and submit them to OMB for that agency's review and approval. HCFA has indicated significant adjustments its original positions on the CMNs and has indicated that the final revised CMNs will reflect positive responses to the HME industry's and physicians' concerns. **An evaluation of the revised CMNs as submitted by HCFA to the OMB on December 19 will be necessary to confirm these indications of genuine responses to the expressed concerns.**

With regard to the CMN issues, HCFA indicated the following:

Creating a "one-page" CMN - HCFA is experimenting with each of the CMNs in an attempt to turn as many of the forms as possible into one page forms. There are possibly one or two items with significant accessories to be listed that would not make the form amenable to a one page format. One such item identified during the meeting was non-standard wheel chairs.

Warranty information - HCFA said that request for warranty information will be removed from the CMNs. HCFA will develop a separate collection process to obtain the warranty information as necessary to protect Medicare from paying for repairs and maintenance that should be covered by warranties.

HME Services Provider Completion of the Physician Phone Number and UPIN - HCFA indicated that the physician name, address, phone number and UPIN information will be moved from section B to another part of the form and therefore will be allowed to be completed by the HME services provider.

Definition of "financial relationship" - HCFA has decided to forgo using the term "financial relationship" and return to the previous statement on the form that "The supplier may not fill out information in Section B." HCFA may require the person actually filling out the form provide their name, title and affiliation, if other than the physician.

Cover letter contents - Though an issue peripheral to the "form", HCFA addressed provider questions regarding clarification of the content of the CMN cover letter. HCFA has decided to return to the clarifications of the content of the cover letter contained in a memorandum issued by the agency several years ago, i.e., an HME provider is permitted to use a cover letter as a review and confirmation of the physician's instructions in ordering the item, provided that the cover letter does not change the physician's order and does not provide answers to the questions in Section B of the CMN. Potential conflicts as to when recorded information could be construed as providing answers to the questions was discussed, without resolution except for a statement by the agency that a "common sense" approach should be used in audits of cover letters by the DMERCs. Follow-up with the agency for clarification on this issue is necessary.

Physician attestation statement - Responding to the physicians' concerns, HCFA will change the attestation statement to say that the physician has received the information completed by the HME services provider and that the information the physician has completed is true and correct.

Potential Problem:

Automation of the Forms - Currently, computer software vendors provide the HME industry with programs that permit the HME providers' computer printers to print on blank paper the entire form and/or pertinent questions of each form related to the equipment ordered. HCFA appears to be leaning toward the position that once these forms are "approved by OMB as government forms," these types of computer software capabilities will no longer be allowed. This will be a serious inconvenience for fully automated billing operations and catastrophic to the various software companies serving the industry. NAMES is disappointed with HCFA's disregard of the current investment in automation hopeful that the OMB will allow maximum flexibility for the reproduction of the approved forms by computer automation by allowing for the appropriate variations in the final approval of the CMN formats.

EXHIBIT #1

Examples of Industry Developed One-Page CMNs

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 01.02A

Certificate of Medical Necessity: Hospital Beds

Section A Supplier Completion Section Certification Type/Date: Initial __/__/__ Revised __/__/__

PATIENT NAME, ADDRESS and HIC NUMBER

TELEPHONE (___)___-____ HICN_____

SUPPLIER NAME,TELEPHONE and NSC NUMBER

TELEPHONE (___)___-____ NSC#_____

Description of All Equipment	HCPCS Code	Supplier Price	Medicare Allowable

PLACE OF SERVICE __Home __Nursing Facility __Other _____ Patient Sex __F __M Patient DOB __/__/__

Estimated Length of Need (In Months):_____1-99 (99=Lifetime) Diagnosis Codes (ICD-9): _____ _____ _____ _____

PHYSICIAN NAME, ADDRESS, UPIN AND TELEPHONE (Printed or Typed)

Telephone:_____

UPIN:_____

Section B **Information below may not be completed by the supplier, or an employee of the supplier, of the items/services.**

ANSWERS **Answer Questions as follows: Manual Hospital Bed Questions 1 and 3 thru 5**
Manual Hospital Bed with Height Adjustment Questions 1 and 3 thru 6
Electric Hospital Bed with Height Adjustment Questions 1 and 3 thru 5 and 7

__Yes __No __Does not apply	1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?
__Yes __No __Does not apply	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
__Yes __No __Does not apply	4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?
__Yes __No __Does not apply	5. Does the patient require traction which can only be attached to a hospital bed?
__Yes __No __Does not apply	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
__Yes __No __Does not apply	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Printed to Typed)

Name:_____ Title:_____

PHYSICIAN ATTESTATION, SIGNATURE and DATE:

I, the patient's physician, certify that I have received Sections A and B of this Certificate of Medical Necessity (including charges for items ordered). I certify the medical necessity of these items for this patient. I have reviewed the answers in Section B of this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. The foregoing information is true, accurate and complete, to the best of my knowledge, and I understand that may falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE___/___/___

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

*** *NAMES SAMPLE VERSION* ***

Certificate Of Medical Necessity: HOSPITAL BEDS

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____ NAME of FACILITY _____	PT DOB ___/___/___ Sex ___ (M/F)

HCPCS CODES	NARATIVE	CHARGE	ALLOW	REPLACEMENT (check if applicable)	WARRANTY (see reverse) (Length months)	Type (1-4)

Narative Diagnosis: 1. _____ 2. _____
3. _____ 4. _____

SECTION B Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor Anyone In A Financial Relationship With The Supplier.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	
	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (Circle Y for Yes, N for No, or D for Does Not Apply)
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.
Y N D	1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

SECTION D Physician Attestation and Signature/Date

I, the patient's physician, certify that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including charges for items ordered). I certify the medical necessity of these items for this patient. I have reviewed the answers in Section B of this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. The foregoing information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 12/2/95

Effective 11 DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 01.02

Certificate of Medical Necessity: Hospital Beds/Support Surfaces

Section A (THE SUPPLIER MAY FILL IN INFORMATION IN SECTION A)

Certification: ☐ initial ☐ recertification ☐ revised
Effective date: _____ ☐ this is a replacement item

Patient name:
HIC #:

Supplier name
Address:

Telephone #: NSC #:

Diagnosis (ICD-9)	Description		

HCPCS	Description		

Section B (UNLESS OTHERWISE INDICATED ONLY THE PRESCRIBING PHYSICIAN OR A PHYSICIAN EMPLOYEE MAY FILL IN INFORMATION BELOW THIS LINE)

Estimate the length of need in number of months from 1-99 (99 = lifetime): _____

Answer for ALL HOSPITAL BEDS: *(check one: Y = yes; N = no; D = does not apply unless otherwise noted)*	supplier completion permitted	physician completion ONLY
1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?		[Y] [N] [D]
2. (reserved)		
3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?		[Y] [N] [D]
4. Does the patient require the head of the bed to be elevated more than 30° most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?		[Y] [N] [D]
5. Does the patient require traction which can only be attached to a hospital bed?		[Y] [N] [D]
Answer for VARIABLE HEIGHT BEDS *(manual height, head and leg elevation adjustments)*:		
6. Does the patient require a bed height different than a fixed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?		[Y] [N] [D]
Answer for SEMI-ELECTRIC BEDS *(manual height and electric head and leg elevation adjustments)*:		
7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?		[Y] [N] [D]
8, 9, 10, 11 (reserved)		
Answer for ALTERNATING PRESSURE PADS/MATTRESSES:		
12. Is the patient highly susceptible to decubitus ulcers?		[Y] [N] [D]
13. Are you directing the home treatment regimen for this item?		[Y] [N] [D]
Answer for AIR-FLUIDIZED BEDS *(warm air passed through ceramic beads to simulate fluid movement)*:		
13. Are you directing the home treatment regimen for this item?		[Y] [N] [D]
14. Does the patient have coexisting pulmonary disease? (Note: An AFB cannot be elevated/is contraindicated if head elevation is required.)		[Y] [N] [D]
15. Has a conservative treatment program been tried without success?		[Y] [N] [D]
16. Was a comprehensive assessment performed after failure of conservative treatment?		[Y] [N] [D]
17. Is the home electric system sufficient for the anticipated increase in energy consumption?	[Y] [N] [D]	
18. Is structural support adequate to support the air-fluidized bed?	[Y] [N] [D]	
19. Are open, moist dressings used for the treatment of the patients? (Note: An AFB will dry out a moist dressing.)		[Y] [N] [D]
20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?	[Y] [N] [D]	

21. Provide the stage and size of each pressure area/ulcer necessitating the use of the overlay mattress or bed. (Note: If the AFB is being prescribed for preventive reasons — prior to the manifestation of a pressure area/ulcer — enter "0" in the size, length, width columns.) Patient must exhibit an appropriate combination of risk factors, i.e. blood or circulatory deficiencies, weight and/or nutrition problems, chronic illness, past history of decubiti, incontinence and/or immobility. (See reverse.)
Risk factors:

	1	2	3
Stage:			
Max length (cm):			
Max width (cm):			

22. Over the past month, the patient's ulcer(s) has/have: 1) improved; 2) remained the same; 3) worsened

Physician name, address and telephone #:

UPIN:

I certify the medical necessity of these items for this patient. Section B of this form and any statement over my signature attached hereto has been completed by me, or by my employee and reviewed by me. I certify that I examined this patient prior to ordering the medical equipment. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____ / /
physician's signature (a stamped signature is not acceptable) date (required)

NAMES

National Association for
Medical Equipment Services

Statement

of the

National Association for

Equipment Services

on

Fraud and Abuse

in the Medicare System

Before

the

Health Care Financing

Administration

Tuesday, August 29, 1995

Washington, DC

625 Slaters Lane • Suite 200 • Alexandria, VA 22314-1171 • (703) 836-6263 FAX (703) 836-6730

NAMES

National Association for
Medical Equipment Services

Good Morning. I am William D. Coughlan, President and CEO of the National Association for Medical Equipment Services (NAMES), the only national association exclusively representing the home medical equipment (HME) services industry. NAMES welcomes this opportunity to present our comments about improving and preserving the solvency of the Medicare program by ending fraud and abuse.

NAMES members comprise approximately 1800 HME companies which provide quality, cost-effective services and rehabilitative/assistive technology to patients in their homes. According to physician prescription, HME providers furnish a vast array of HME and related services, ranging from "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and state of the art rehabilitation equipment customized for the unique needs of people with disabilities. Many of these consumers are Medicare beneficiaries.

NAMES takes pride in its mission to promote access to quality HME services and rehab/assistive technology and has devoted significant resources for several years to combat fraud and abuse. The industry has worked diligently with the Administration and Congress to help eliminate the few unethical providers who damage the reputation of an otherwise upstanding industry.

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Recently, NAMES took a serious look at the specific problems with the provision of HME services and rehab/assistive technology in the Medicare program. The following reflects our solutions to those problems, which we believe will potentially save the Medicare program millions of dollars by changing the inherent system weaknesses that encourage fraud and abuse.

- **Accountability Measures--The Need for Standards.** We have advocated for years that there must be stronger accreditation, certification and/or licensure requirements for HME service providers, including on-site inspections. Despite the work of NAMES and HME providers to create a higher level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding the type or frequency of services that should be rendered, record-keeping practices, emergency care, patient education, home safety assessments or infection control practices.

- **Consistent Monitoring of the HCFA Common Procedure Coding System (HCPCS) Codes.** The HCPCS codes are currently updated only on a yearly basis. One of the abusive areas in HME is rooted in questionable coding practices, made possible by the inadequacy of codes to reflect technological advances. HCFA should change the coding

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system and establish appropriate fees for new codes on a quarterly basis. Increased agency vigilance could eliminate problems that have occurred, such as the situations with support surfaces and lymphedema pumps. Provider and manufacturer input will be necessary to make these quarterly coding adjustments meaningful. We believe HCFA has the authority to undertake this project now, for HME, at the Durable Medical Equipment Regional Carrier (DMERC) level. The quarterly carrier coding and new fee adjustments could still be ratified on an annual basis by HCFA.

NAMES would also advocate that HCFA create a **Manufacturer and Provider Advisory Committee** to assist in adjusting the HCPCS Codes and to recommend appropriate descriptors to help identify emerging technology.

- **Optional Electronic Preauthorization.** Assistive technology and special wheelchair systems require building and delivery prior to claims submittal. HCFA has no set time period for claim adjudication and guaranteed payment. We have received information which suggests that some providers may be submitting claims and paperwork indicating the equipment has been delivered, when in fact they have not even begun constructing the equipment. Providers are unfortunately forced into this otherwise abusive practice in order to get advanced assurance of Medicare coverage and payment for costly,

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complex equipment that has been prescribed by the physician. Otherwise, these providers run the risk of serious financial commitment to equipment construction with no guarantee of any, much less adequate, reimbursement.

HCFA is under a statutory mandate to create a prior authorization system for customized assistive technology, but to date, has not issued specifications on how that preauthorization will operate. As long as HCFA and the DMERCs lack the technical expertise to evaluate individual patient need for assistive technology, the risk of serving such Medicare beneficiaries will continue to be unacceptably high for HME assistive technology providers.

- **Equipment Upgrades.** Under the current system, a Medicare beneficiary with a prescription who wishes to purchase certain pieces of equipment may be unable to do so. For instance, a beneficiary who has a prescription for a full-electric hospital bed to meet his/her physical needs is prohibited by Medicare from purchasing the bed. Although Medicare will pay for the rental of a semi-electric bed, a full-electric bed has been deemed by the DMERCs to be medically unnecessary under any circumstances, even as originally prescribed by the physician. In essence, regardless of the patient's medical needs or a physician's prescription, Medicare makes the final medical need and payment

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decisions.

Often, when a beneficiary needs an item of medical equipment the provider will bill Medicare for the item and Medicare may deny payment and instead substitute another item that costs Medicare less. This is referred to as "down coding". In addition, Medicare denies the beneficiary the ability to "upgrade" and receive his/her equipment of choice. NAMES strongly supports legislative efforts to allow equipment upgrades for Medicare beneficiaries. In the interim, NAMES recommends that HCFA halt the practice of "down coding" equipment and issue the appropriate and honest claim denials for non-covered equipment, rather than second-guessing the physician, beneficiary, and HME services provider regarding the equipment choice.

In closing, NAMES recognizes the difficulties faced by this Administration and Congress in developing a responsible legislative and regulatory package that will reduce Medicare fraud and abuse while addressing America's critical health care needs. By enacting the suggested provisions, the solvency and integrity of the Medicare program could be preserved while achieving significant savings.

We also call for the GAO to score the issue of Medicare fraud and abuse. For example, at a "Medicare University" held earlier this month in Washington, DC, sponsored by the

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Citizens Against Government Waste (CAGW) and the Coalition to Save Medicare, CAGW President Thomas Schatz estimated the amount of Medicare fraud and abuse at $17 billion per year; $46 million per day. He also pointed out that there are no HHS OIG investigators in 25 states where Medicare spent more than $26 billion covering 7 million beneficiaries. Why won't HHS hire aditional investigators on the state level who can then perform on-site evaluations of providers.

We will be pleased to answer any questions you may have. Thank you for inviting us to submit our comments.

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NAMES
National Association for
Medical Equipment Services

EXTENDED COMMENTS

August 29, 1995
HCFA Listening Session
Washington, DC

In addition to suggested program changes, NAMES is currently working with the Coalition of Associations United Against Fraud and Abuse to assist the Administration and Congress in creating an environment that discourages fraudulent providers from participating in the health care system and encourages quality and cost-effective health care.

NAMES has also been a member since 1993 of the Advisory/Liaison Committee of the National Health Care Anti-Fraud Association (NHCAA), whose mission is to enhance the identification prevention, detection and prosecution of health care fraud. In addition to NAMES, the other members of this committee include: the AMA, the ADA, Health Insurance Association of America, the NAHC, and the Coalition Against Insurance Fraud.

The Coalition of Associations United Against Fraud and Abuse is made up of organizations that represent health care providers and suppliers who believe that existing fraud and abuse statutes must:

- Increase tools of enforcement against willful and criminal violations by giving regulators budgetary recognition and sufficient resources to enforce the law;
- Provide adequate and thorough education for providers, consumers, and payers to prevent violations;
- Protect Federal health care programs from unnecessary cost, utilization, and the failure to deliver appropriate levels of care;
- Be appropriate for the changing health care market; and
- Separate willful from technical violations.

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In addition, the Coalition is urging Congress to adopt the following proposals to help eliminate health care fraud and abuse. Most of the following items require changes to the Medicare statute, however, some could be implemented by HCFA within its current administrative authority. NAMES is hopeful that the Agency will evaluate and implement these suggestions as appropriate.

I. Tools of Enforcement

Federal Regulators should have the ability to prosecute fraudulent health care providers and suppliers.

A. **Establish a new health care fraud statute in the criminal code.** Providing penalties of up to ten years in prison, or fines, or both for willfully and knowingly executing a scheme to defraud a health plan in connection with the delivery of health care benefits, as well as for obtaining money or property under false pretenses from a health plan will help as a deterrent to fraud.

B. **Provide for the creation of an Anti-fraud and Abuse Collection Account.** An account subject to the congressional appropriations process will provide the Office of the Inspector General and the Federal Bureau of Investigation with the resources necessary to prosecute fraudulent providers and suppliers, and to provide guidance to those who seek to comply with the law.

C. **Clarify Antikickback Statute.** The current antikickback statue is vague and not focused on fraudulent activity. This provision would ensure that the antikickback law applies to those who intentionally defraud the government by codifying the Hanlester Network vs. Shalala decision. In this case, the court ruled that "knowingly and willfully" committing a fraudulent act should be the basis of federal prosecution. In addition, there is a clarification to the longstanding issue that an action is illegal,if a "significant or substantial reason" for making a payment is to induce referrals.

D. **Additional Enforcement Tools.** In addition to criminal prosecution, regulators are given the following enforcement tools to punish those found to commit a health care fraud offense:

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1. **Exclusion from Federal and State Health Care Programs.** Mandatory exclusion from Medicare and state health care programs to those convicted of a health care felony. Increase existing permissive exclusion and apply it to an officer in an entity that has been convicted of a health care offense, if that officer is found to have a "reason to know" that the crime was committed; and

2. **Expansion and increase in civil monetary penalties.** Expanding penalties will serve as an appropriate deterrent.

II. Health Care Fraud and Abuse Guidance

It is the belief of the coalition that the vast majority of providers and suppliers seek to comply with the complex laws of Medicare and Medicaid. We further believe that much of the "noncompliance" can be resolved with education and guidance. The following provides mechanisms for further guidance to health care providers on the scope and applicability of the anti-fraud statutes.

A. **Safe Harbors.** Updates existing safe harbors and creates new ones.

B. **Fraud Alerts.** Establishes a formal process for the request and issuance of special fraud alerts.

C. **Advisory Opinions.** Advisory opinions assist providers and others engaged in the delivery of health care to ensure that they remain in compliance with health care statutes and regulations.

III. Medicare Claims Process

The General Accounting Office (GAO) in its report entitled "Medicare Claims _ Commercial Technology Could Save Billions Lost to Billing Abuse" (May 1995) stated "Flawed payment policies, weak billing controls, and inconsistent program management have all contributed to Medicare's vulnerability to waste, fraud, and abuse." The following provisions will improve that process.

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A. **Medicare Transaction System (MTS).** Downgrade the priority or terminate the development of the Medicare Transaction System.

B. **Commercial Automatic Data Processing Equipment (ADPE).** Require Medicare carriers to acquire commercially made Commercial Automatic Data Processing Equipment.

C. **Reduce number of Medicare Carriers to ten.** Upon implementation of the ADPE, HCFA should be required to study and report to Congress on reducing its 32 Medicare Part B carriers to 10 such as the Durable Medical Equipment Regional Carriers (DMERCs) that were reduced to four. This will help to foster better communication between HCFA and the Regional Carriers.

D. **Contractor/Provider Relationships.** Prohibit Medicare carriers and intermediaries from reviewing claims of provider organizations when the Medicare contractor has an investment in that organization;

E. **Study Fraud and Abuse Under Managed Care.** The rise in managed care brings new forms of fraud and abuse. For example, the government and beneficiaries may be defrauded through withholding necessary services. The Institute of Medicine should undertake a study on the types of fraud that it may encounter under managed care and to begin ways to detect and combat such fraud.

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intro Bill Cowlin
—?

Med Necessity
paperwork

Reg to cut oxygen
payment
Ovr reg on hold

industry to OMB
met this wk

Back to 1 page

HEALTH CARE FINANCING ADMINISTRATION

Medical Necessity

ADDRESSEE:	FROM: Jennifer Boulanger
Diana Fortuna	OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
PHONE: _____	PHONE: 202-690-6726 FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
C+4		6/28

REMARKS:

Medical necessity form for hospital beds. There are different forms for different pieces of DME. The third optional page was dropped by BPO 2-3 wks ago (as it turns out, they told the suppliers DMERCs not to use it earlier, but the DMERCs persisted. BPO told the DMERCs again and, supposedly, the third page has been dropped). The additions required from Soc. Secty Amend of 94 were the charge and fee schedule amounts must be included on the form (Sec. 2)

Effective 10/01/95 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** DMERC 01.02A

CERTIFICATE OF MEDICAL NECESSITY: HOSPITAL BEDS PAGE 1 OF 2

SECTION A CERTIFICATION TYPE/DATE: INITIAL __/__/__ REVISED __/__/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB __/__/__; Sex___ (M/F)

HCPCS CODES	REPLACEMENT (check if applicable)	WARRANTY Length(months)	WARRANTY Type (1-4) (see reverse)
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

SECTION B INFORMATION BELOW MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES, NOR ANYONE IN A FINANCIAL RELATIONSHIP WITH THE SUPPLIER.

EST. LENGTH OF NEED (# OF MONTHS): ___ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): ____ ____ ____ ____

ANS: Y N	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (CIRCLE Y FOR YES, N FOR NO, OR D FOR DOES NOT APPLY)
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.
Y N D	1. DOES THE PATIENT REQUIRE POSITIONING OF THE BODY IN WAYS NOT FEASIBLE WITH AN ORDINARY BED DUE TO A MEDICAL CONDITION WHICH IS EXPECTED TO LAST AT LEAST ONE MONTH?
Y N D	3. DOES THE PATIENT REQUIRE, FOR THE ALLEVIATION OF PAIN, POSITIONING OF THE BODY IN WAYS NOT FEASIBLE WITH AN ORDINARY BED?
Y N D	4. DOES THE PATIENT REQUIRE THE HEAD OF THE BED TO BE ELEVATED MORE THAN 30 DEGREES MOST OF THE TIME DUE TO CONGESTIVE HEART FAILURE, CHRONIC PULMONARY DISEASE, OR ASPIRATION?
Y N D	5. DOES THE PATIENT REQUIRE TRACTION WHICH CAN ONLY BE ATTACHED TO A HOSPITAL BED?
Y N D	6. DOES THE PATIENT REQUIRE A BED HEIGHT DIFFERENT THAN A FIXED HEIGHT HOSPITAL BED TO PERMIT TRANSFERS TO CHAIR, WHEELCHAIR, OR STANDING POSITION?
Y N D	7. DOES THE PATIENT REQUIRE FREQUENT CHANGES IN BODY POSITION AND/OR HAVE AN IMMEDIATE NEED FOR A CHANGE IN BODY POSITION?

NAME OF PERSON ANSWERING ABOVE QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): _____

TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Effective 10/01/95 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** DMERC 01.02A

CERTIFICATE OF MEDICAL NECESSITY: HOSPITAL BEDS PAGE 2 OF 2

PATIENT NAME: _____ HICN: _____

SECTION C: NARRATIVE DESCRIPTION OF DIAGNOSES GIVEN BY PHYSICIAN; NARRATIVE DESCRIPTION OF ALL ITEMS, ACCESSORIES, OPTIONS, SUPPLIES AND DRUGS ORDERED; SUPPLIER'S CHARGE AND FEE SCHEDULE ALLOWANCE FOR EACH ITEM, ACCESSORY, OPTION, SUPPLY AND DRUG.

(SEE INSTRUCTIONS ON BACK)

SECTION D: PHYSICIAN ATTESTATION and SIGNATURE/DATE

I, THE PATIENT'S PHYSICIAN, CERTIFY THAT I HAVE RECEIVED SECTIONS A, B, AND C OF THIS CERTIFICATE OF MEDICAL NECESSITY (INCLUDING CHARGES FOR ITEMS ORDERED). I CERTIFY THE MEDICAL NECESSITY OF THESE ITEMS FOR THIS PATIENT. I HAVE REVIEWED THE ANSWERS IN SECTION B OF THIS FORM. ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO, HAS BEEN REVIEWED AND SIGNED BY ME. THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___

SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/YY/DD) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order based on the patient's changing clinical needs), then also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the recertification date in the space marked, "RECERTIFICATION." In addition to completing "INITIAL" date space. Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish INITIAL date as well as REVISED or RECERTIFICATION date.
BENEFICIARY INFORMATION:	Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim form.
PLACE OF SERVICE	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PATIENT DOB, HEIGHT, WEIGHT AND SEX	Indicate patient's date of birth (MM/DD/YY), height in inches (optional), weight in pounds, and sex (male or female).
HCPCS CODES, REPLACEMENT, WARRANTY:	List all HCPCS procedure codes for items ordered that require a CMN (write the HCPCS narrative definition for codes listed on attached Written Confirmation of Physician's Order). Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1) Full replacement, (2); Pro-rated replacement, (3), Parts & Labor; (4) Parts Only.

SECTION B: (May not be completed by supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES	In the first space, list the ICD9 code that represents the primary reason for ordering the item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).
QUESTION SECTION	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number, if this is offered as an answer option, or fill in the blank, if other information is requested.
ITEM ADDRESSED COLUMN.	If this column appears on the CMN, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must print his/her name and give his/her professional title where indicated. If the physician is answering the questions, this space may be left blank.
PHYSICIAN NAME, ADDRESS:	Indicate physician's name and complete mailing address.
UPIN	The physician must indicate his/her Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO.	The physician must give a telephone number where he/she can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.

[redacted]

PEBA

SECTION C: (To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST:

Supplier confirms physician's original order, giving (1) a narrative description of diagnoses (not ICD-9 Dx codes), justifying the medical necessity of the items requiring this CMN; (2) a narrative description of the item or items ordered, as well as all options, accessories, supplies and drugs, (3) the supplier's charge for each item, option, accessory supply and drug. Also to be listed is the fee schedule for each item/option/accessory if applicable.

SECTION D: (Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D. Section A contains all pertinent supplier information. Section B contains questions establishing medical necessity of the equipment prescribed for this patient, which has not been completed by the supplier, nor anyone with a financial relationship with the supplier. Section C is provided for the physician's review for accuracy of diagnoses and items ordered.

PHYSICIAN SIGNATURE AND DATE:

After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.