CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 693	**Date: December 30, 2016**
	Change Request 9910

SUBJECT: Clarification of Appeal Rights for Denials Stemming from Statutory Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the language in the Chapter 5, section 5.5.2.3 of Pub. 100-08 related to appeal rights stemming from denials for failures to comply with statutory requirements. The updated language works to ensure that parties to an initial determination receive their statutorily-guaranteed due process rights to appeal their initial determinations, and clarifies the relationship between the right to appeal and limitation on liability provisions. This language is consistent with the instructions located in the current regulation and Pub. 100-04.

EFFECTIVE DATE: January 31, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 31, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/5.2/5.2.3/Detailed Written Orders

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 693	Date: December 28, 2016	Change Request: 9910

SUBJECT: Clarification of Appeal Rights for Denials Stemming from Statutory Requirements

EFFECTIVE DATE: January 31, 2017
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I. GENERAL INFORMATION

A. Background: The Medicare contractor makes an initial determination when a claim for Medicare benefits under Part A or Part B is submitted. A party to the initial determination may request that the contractor perform a redetermination of the claim, provided the request for redetermination is filed within the applicable timeframe and the request has the appropriate information. The scope of what is considered to be an initial determination is broad to ensure that due process is afforded to parties to the initial determination.

Section 1879(a)-(g) of the Social Security Act (the Act) provides financial relief to beneficiaries, providers and suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare coverage and payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision." The basic purpose of this provision is to protect beneficiaries and other claimants from liability for certain statutorily-specified denial reasons and conditions. The primary factors that determine whether Medicare payment is made are the reason for the denial and what party knew or could reasonably have been expected to know that the items or services were not covered.

This CR updates the language in chapter 5 of Pub. 100-08 that is related to appeal rights stemming from denials for failures to comply with statutory requirements. The updated language works to ensure that parties to an initial determination receive their statutorily-guaranteed due process rights to appeal their initial determinations, and clarifies the relationship between the right to appeal and limitation on liability provisions. This language is consistent with the instructions located in the current regulation and Claims Processing Manual (100-04).

B. Policy: Section 1879(a)-(g) of the Act.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9910.1	Contractors shall follow the guidelines in the claims processing manual regarding appeal rights and limitations on liability for benefit category denials.				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov , Joella Roland, 410-786-7638 or Joella.Roland2@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

5.2.3 – Detailed Written Orders

(Rev.693; Issued: 12-30-16; Effective: 01-31-17; Implementation: 01-31-17)

All DMEPOS items other than those referenced in 42 CFR 410.38(c)(4) and 410.38(g)(2) require detailed written orders prior to billing. Detailed written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document. (See chapter 3, section 3.3.2.4).

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. All orders must clearly specify the start date of the order.

If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need. For example, an order for surgical dressing might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for 1 month or until the ulcer heals.

If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable).

Someone other than the physician may complete the detailed description of the item. However, the treating physician/practitioner must review the detailed description and personally sign and date the order to indicate agreement.

The supplier must have a detailed written order prior to submitting a claim. If a supplier does not have a faxed, photocopied, electronic or pen and ink detailed written order signed and dated by the treating physician/practitioner in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category, and *if the error cannot be cured, or where it can be cured it is not cured within the prescribed timeframe, there may be financial implications for the beneficiary* (see Pub. 100-04, chapter *30*, for more information on *limitation on liability*). For all other items (except those listed in section 5.2.4), if the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary.

Medical necessity information (e.g., applicable diagnosis code, narrative description of the patient's condition, abilities and limitations) is NOT in itself considered to be part of the order although it may be put on the same document as the order.