DME INTAKE AND BILLING · CHECKLIST

DME Claim Documentation Checklist

A denied DME claim is often missing a piece of the file, not a code. Walk the account in this order before the first claim goes out, and again when you bill a refill or another rental month. If a box is empty, pause the claim and fix the file first.

1. Standard Written Order (SWO)

For Medicare dates of service on or after January 1, 2020, a complete SWO has to be in your hands before you submit the claim. Someone other than the treating practitioner may complete it, unless a statute, manual, or LCD says otherwise, but the practitioner still has to review the content and sign. Signature and date stamps are not allowed.

- [ ] Beneficiary's name or Medicare Beneficiary Identifier (MBI) is on the order.
- [ ] The order date is present and readable.
- [ ] The item is described clearly — a general name (for example, hospital bed), a HCPCS code or narrative, or a brand and model.
- [ ] Separately billed options, accessories, or supplies are listed on their own lines, not buried in a single description.
- [ ] Quantity to be dispensed is stated, when it applies.
- [ ] The treating practitioner's name or NPI is on the order.
- [ ] The treating practitioner signed the order. No stamps.
- [ ] The completed SWO reached you before the claim was filed.
- [ ] The medical record actually supports what the order says. A prescription is not a substitute for the chart.

2. WOPD and face-to-face — only when the item is listed

A Written Order Prior to Delivery is a complete SWO that must reach you before the item is delivered, and only for items on CMS's current Required Face-to-Face Encounter and Written Order Prior to Delivery List (including statutory power mobility devices). Most DMEPOS items do not need a WOPD. They only need the SWO before you bill. Check the current CMS list. Do not go by memory; the list changes.

- [ ] You confirmed whether this HCPCS is on CMS's current Required List.
- [ ] If it is listed, a complete SWO was in your file before delivery — not after the truck left.
- [ ] A face-to-face encounter took place within six months before the order.
- [ ] The visit notes are about this beneficiary and support the condition the item is meant to treat.
- [ ] If the visit was telehealth, it met Medicare telehealth service and payment rules.
- [ ] You can produce the order and the supporting visit documentation if CMS or a DME MAC asks for them.

3. Proof of delivery (POD)

Keep proof of delivery in the file and be ready to produce it. The delivery record should match the item you actually billed, not a similar SKU from the same shelf.

- [ ] The delivery date is documented.
- [ ] The item description matches what was ordered and billed, including make and model when you have them.
- [ ] The quantity on the POD matches the claim.
- [ ] The beneficiary or a designee signed, or the proof required for that delivery method is complete.
- [ ] The delivery address is on the form.
- [ ] For refills, you have a documented refill contact and a new POD for that shipment.

4. CMN and DIF — know which payers still use them

Medicare retired Certificate of Medical Necessity (CMN) and DME Information Form (DIF) forms for most dates of service beginning January 1, 2023. The clinical story still has to live in the medical record. Some Medicaid and commercial plans kept their own forms, so the payer in front of you still matters.

- [ ] For Medicare, you are not holding the claim for a retired CMN or DIF. The chart supports the coverage criteria.
- [ ] If the payer is Medicaid or commercial, you checked whether that plan still requires a CMN or an equivalent form.
- [ ] Any plan-specific form is complete, signed, and dated before you bill that payer.

5. The KX modifier and the rest of the claim line

KX means the coverage criteria are met and the documentation is on file. If that is not true, leave it off. Adding KX to “get the claim paid” is how reviews turn into recoupments.

- [ ] The LCD or policy criteria for this item are met in the record.
- [ ] KX is used only when that is true.
- [ ] If the criteria are not met, you used the liability modifier the situation calls for (GA, GY, or GZ) instead of guessing.
- [ ] Purchase and rental modifiers are correct (NU, UE, or RR), and any capped-rental month modifier matches the real month.
- [ ] If the item needs prior authorization, you have an affirmation and the Unique Tracking Number (UTN) on the claim.

6. Last look before the claim leaves

- [ ] Eligibility and same-or-similar have been checked.
- [ ] The HCPCS fits the product you actually delivered, including a PDAC Product Classification List check when that code requires it.
- [ ] The file is already in a shape you could send if a documentation request arrives.

Related Salyx reading and sources

Related reading: SWO / WOPD checklist for DME suppliers; PDAC / HCPCS verification checklist; DME billing services. Sources: CMS DMEPOS Order and Face-to-Face Encounter Requirements; CMS MLN tip on DMEPOS general documentation requirements; Noridian JD DME Standard Written Order guidance. Required lists and payer rules change — verify the current CMS and DME MAC materials before you deliver or bill.