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Implementation of Automating First Claim Review in Serial Claims for DMEPOS

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The Centers for Medicare & Medicaid Services (CMS) considers serial claims to be claims that are so closely related to one another that the same payment decision should be applied to each claim. In general, serial claims are for the same Healthcare Common Procedure Coding System (HCPCS) code and same beneficiary.

CMS plans to implement a system that will enable the DME MACs to perform a pre-payment complex medical review on a claim line and then, based on the results of the complex medical review:

1. Pay subsequent claims in the series after passing existing validation edits, OR
2. Deny subsequent claims in the series unless the provider submits additional documentation with the subsequent claim line.

Providers and suppliers should be aware that if a serial claim is denied after a complex medical review, subsequent claims in the series will be denied unless additional documentation is submitted to demonstrate that the services are reasonable and medically necessary. The process used to submit additional documentation will depend on how the claim is submitted:

- ⇒ If a paper claim is submitted, any additional documentation must be attached to the claim form.
- ⇒ If an electronic claim is submitted, the existing PWK process must be followed and the claim must also include the word “serial” in the NTE segment. (Refer to MLN article MM7041 for the existing PWK process.)

Make sure your billing staff is aware of these changes.