

Region B DMERC Frequently Asked Questions

Home Medical Equipment:

1. Question: Ever since the new seating policy went into effect, the back cushions have been getting denied for PR-B17 (needs certificate of medical necessity [CMN]). I have received answers from customer service ranging from: attach a “mock” CMN (which would not pass through electronic data interchange [EDI]); a modifier is missing (why not use the “missing/invalid proc code/modifier” rejection code?); and the claim will be sent through for reprocessing. Why is this happening and is there anything being done to correct it?

Examples were received and reviewed by AdminaStar Federal. A system problem was identified and corrected. Claims for the new wheelchair seating policy will no longer deny for lack of a CMN. A mass adjustment will be done to correct the affected claims from January 1, 2005 through May 31, 2005 when the problem was corrected.

Please remember modifier KX should be used with these claims when applicable.

2. Question: We have gotten denials for same/similar equipment involving wheeled walkers. The issue of resolving this type of denial was addressed in frequently asked questions (FAQ) from September of 2004. We are asking our customers if they have had a walker in the past that was paid for by Medicare. When the customers answer “NO,” they have not had a walker in the past, short of getting an advance beneficiary notice (ABN) for every walker we sell, how can we determine if, in fact, Medicare has previously paid for a walker for a particular customer? We are trying to determine our customer’s history by asking them directly but this is not fool-proof, so where else would this information be available to avoid these problems? How elaborate should our process be to “determine the patient’s history?”

If unable to secure this information from the beneficiary, or if uncertain as to the accuracy of the information provided by the beneficiary, an ABN should be used. The Centers for Medicare & Medicaid Services (CMS) considers same/similar denials a type of frequency denial, and ABNs can be given to beneficiaries for these types of denials predicated on the supplier’s expectation that Medicare will deny payment for the item/service. In situations where the beneficiary is unsure if previous equipment has been provided, durable medical equipment regional carrier (DMERC) suppliers may also utilize three-way calling with the beneficiary on the line to Customer Service as another avenue to determine whether or not the patient has had same or similar equipment.

3. Question: What is the correct way to submit a claim to Medicare for an upgraded walker? The walker is coded with HCPCS code E0143 (per Statistical Analysis Durable Medical Equipment Regional Carrier [SADMERC]); seat E0156. We have waivers signed stating Medicare only allows for a standard walker and the patient will be responsible for the difference between the standard and upgrade. Medicare Review denies stating we have not given sufficient notice.

Medicare covers a seat (HCPCS code E0156) when it is ordered by a physician and is medically necessary. No “upgrade” is involved in the situation that is described.

4. Question: Does Medicare allow for the purchase of a walker (for transfer to the bed or commode) at the same time the patient is renting a wheelchair?

In general, if a patient was using a wheelchair to meet his/her chronic mobility needs, a walker would not be medically necessary. One exception would be a situation of active rehab in which the patient was using a walker with the expectation that the wheelchair would be needed for only a short period of time.

Enteral/Parenteral/IV Therapy

5. Question: Documentation for the enteral policy states that a new initial CMN is needed for the pump when the patient is switched from gravity or syringe to pump. The interpretation in Region B seems to be that we need a NEW INITIAL for the pump and another, separate REVISED for the supplies. The need should only be for a REVISED

CMN. Even the oxygen policy only requires an order when the patient switches administration (i.e., gas system to liquid system). This is overly burdensome and impossible to explain to the physicians. Can this be changed?

There are no plans to change this. An initial CMN is needed for the pump because it is a different type of item than the nutrient itself. This is different than the situation in the Oxygen policy in which one type of equipment is being switched to another.

6. Question: In the new external infusion pump policy article, effective April 1, 2005, it states, “An infusion drug not administered using a durable infusion pump must be billed using the appropriate HCPCS code plus modifier GY.” If we bill with modifier GY, will we get a PR denial?

If the drug is not listed as a potentially covered drug in the Infusion Pumps policy, then if it is billed with a GY modifier on a claim without a pump, it will receive a PR denial.

7. Question: We deliver a 30 day supply of enteral formula—patient dies after seven days, according to packaging, formula must be kept at room temperature. We will not get paid for the full month if the patient dies but we should not be taking the formula back because we do not know if the patient/family followed proper storage instructions (per manufacturer) i.e., Ross Ensure Plus states to store at room temperature, even though we instruct patient on proper storage we can not be certain that it is done. Please explain how this should be handled.

AdminaStar Federal will pay for the nutrients shipped. AdminaStar Federal has specific processing guidelines set in place for that scenario.

8. Question: IVIG Policy—Billing for Payment: Please clarify answers to the following scenarios regarding the IVIG policy:

- a. If the coverage criteria of the IVIG policy *are* met *and* the IVIG is administered through an External Infusion Pump, will the drug be paid with the pump and supplies denied? If yes, will the pump and supplies be denied as noncovered or not medically necessary?

The pump and supplies will be denied as not medically necessary.

- i. If the pump and supplies will be denied as not medically necessary, is it correct that an ABN must be obtained in order to bill the patient? **Yes**
 - ii. If the pump and supplies will be denied as noncovered, can we bill the IVIG to Medicare as assigned and bill the pump and supplies to the patient at the time of delivery? **Not applicable**
 - iii. If the coverage criteria of the IVIG policy *are* met *and* the IVIG is NOT administered through an External Infusion Pump, related supplies will deny as noncovered. Can we bill the IVIG to Medicare as assigned and bill the supplies to the patient at the time of delivery? **Yes**
- b. HCPCS codes Q9941, W9942, Q9943, and Q9944 have been established for IVIG drugs effective April 1, 2005. Have the HCPCS codes J1563 and J1564 been eliminated effective April 1, 2005? Please clarify the CMS Change Request 3745.

They are invalid for claims with dates of service on or after April 1, 2005.

- i. For IVIG administered through an External Infusion Pump, dates of service prior to April 1, 2005 are supported by a CMN reflecting codes J1563 or J1564. **Yes**
- ii. For IVIG administered through an External Infusion Pump, dates of service on or after April 1, 2005 should be supported by a CMN reflecting the Q codes. **Yes**
- iii. For patients with dates of service both prior to and after April 1, 2005, are two separate CMNs required? If so, is one an initial and one a revised? **Still researching**

9. Question: Parenteral Nutrition—Billing for Denial: The recent Bulletin describing procedures for billing for denial for infusion therapy relates, of course, to the administration of drugs, not Parenteral Nutrition. Patients must have a permanent impairment of the GI tract in order to qualify for coverage with the test of permanence being at least 3 months. All four DMERC supplier manuals specifically state ‘Parenteral Nutrition will be denied as NONCOVERED in situations involving temporary impairments.’

Therefore, Parenteral Nutrition should be denied as 'noncovered' (PR denial) when the physician answers 'no' in question #1 of section B of the Parenteral Nutrition CMN thus eliminating the requirement for submission of medical records.

Processors in all four Regions continue to deny using 'CO' denials and request additional information in the form of medical records even though such information cannot logically be provided in the absence of GI impairments and/or impairments of less than 3 months. (A recent face-to-face meeting with the DMERC Region A Ombudsman explained that they must have additional documentation even when the aforementioned facts are present and would in fact deny the claim as 'not medically necessary' versus 'noncovered'.)

Please explain the process that providers should follow in order to obtain a 'PR' 'noncovered' denial.

Examples requested from the supplier on May 25, 2005.

Respiratory Care Equipment/Oxygen Therapy

10. Question: Patient started a Continuous Positive Airway Pressure Systems (CPAP) rental E0601 on February 17, 2003. Patient chooses rental option, and Medicare was billed and paid for 15 months of rental. The first maintenance and service (M&S) was scheduled to be billed for November 17, 2004, but on June 19, 2004 the patient returned his CPAP as he could no longer tolerate it. On December 22, 2004 the patient started on AutoPAP per his doctors orders. This is also recognized as HCPCS E0601 although it is a very different machine with different functions. How do we bill for this?

Bill HCPCS E0601MS with a date of service of December 22, 2004. From Medicare's perspective, there was no break in the medical necessity for the CPAP device; therefore a new capped rental period would not begin. Also since AutoPAPs are the same code as standard CPAPs, it makes no difference that treatment was resumed with a different device.

- a. Can we start a new capped rental period for E0601 since there was more than a 60-day break in service, and will Medicare recognize this reason and pay for the new rental of the AutoPAP? **No. See above.**
- b. We can't really charge for M&S on the original CPAP because that equipment was picked up, right? **See above.**
- c. Should the patient sign an ABN? If that answer is yes, what is a Medicare patient supposed to do when that is what their doctor ordered them, because they could not tolerate the CPAP? **No, an ABN is not appropriate because a medical necessity denial is not anticipated.**

11. Question: A patient was on BiPAP-ST for over five years before he became Medicare prime. When he became Medicare eligible and Medicare was primary, the patient did not qualify for BiPAP-ST rental. The patient wanted to self pay for a purchase of the machine. The patient signed an ABN. The claim was filed with a modifier GA, and Medicare denied the claim CO-108. The claim was filed to his secondary insurance, but they would not process as secondary since the denial was CO-108. Why was this not denied with a patient responsibility? I called Medicare and provider assistance said this cannot be purchased because it is under the Medicare category of Frequent and Substantial Servicing. Why can't the beneficiary purchase this equipment if that is what he wants to do and sign the ABN? Can we ever get a PR denial for this?

Waiting for response from the CMS.

12. Question: How should we handle the following? Patient starts on AutoPAP January 2, 2005 and returns the unit February 18, 2005. The supplier downloads the results and the doctor wants to evaluate and set the pressure and decide whether to set up the patient on CPAP/BiPAP. For various reasons, the referring physician takes awhile to do this, and the patient is not set up on CPAP until May 2, 2005. Since there seems to be a break from when the physician gets the results and determines what he wants to do, are we always going to have to send the final months of rental to break in service to extend the CMN for CPAP rental E0601 if the patient chooses rental?

Yes. The correct procedure for Region B DMERC is that all requests for CMN extensions go to Break in Service.

13. Question: The March 2005 *Region B DMERC Supplier Bulletin* indicates suppliers should append the modifier QV to services related to routine costs of clinical trials involving IDE Category A devices. We have been required to use the modifier QV for services related to qualified clinical trials since September 19, 2000 (when billing Part A or Part B). However, when we have submitted claims with this modifier, they have been denied. Will your system accept claims submitted with the modifier QV for dates of service prior to the January 1, 2005 effective date listed in the bulletin? See the CMS Internet Only Manual (IOM), Publication 100-03, *Medicare National Coverage Decision Manual*, section 310.1 and 42 Code of Federal Regulation (CFR) sections 405.21-405.215, 411.15, and 411.406.

Examples requested from Region B Council on May 25, 2005.

14. Question: In the March 2005 questions and answers, question one in the documentation section, Medicare stated that if a supplier initially billed and was paid for a cool humidifier and then billed for a heated humidifier the system is set to deny for same or similar. The policy states, either a nonheated or heated humidifier is covered and paid separately when ordered by the treating physician for use with a covered respiratory assist device. What if it is over five years since they received the cool mist humidifier and the cool mist no longer works? Will Medicare pay for a new humidifier and will it only reimburse for the same HCPCS or can it be the other HCPCS?

If it is over five years since the patient received a cool mist humidifier, a new humidifier could be covered. It could be either a cool mist or heated humidifier, whichever was determined to be medically necessary by the ordering physician.

Prosthetics/Orthotics

15. Question: Our office provided a client with a breast prosthesis and mastectomy bra while the patient was residing at a skilled nursing facility (SNF). Our office understands that prosthesis are a covered item even when a patient is in a SNF. Medicare has denied this claim under MA101 "A SNF is responsible for payment of outside providers who furnish these services/supplies to residents." Please explain coverage of prosthesis in this case. I resubmitted for a redetermination and it was still denied for the same reason.

Breast prosthesis and accessories do fall under the prosthetic benefit category and Medicare will pay for these items when the beneficiary is in a SNF as long as the beneficiary is not under a covered Part A stay. According to the Common Working File (CWF), for the beneficiary provided in this example, the patient was covered under Part A on the date of service in question.

Rehab Equipment

16. Question: We are getting inundated with so much information on HCPCS codes for power wheelchair cushions. What is the most current information we should be using for 2005, and where is it found on the Medicare (CMS) or AdminaStar Web site?

The DMERC policy for Wheelchair Seating can be found on either the AdminaStar Federal web site or in the CMS Medicare Coverage Database. Information on correct coding of wheelchair cushions can be found on the SADMERC Web site in their product classification list.

17. Question: Medicare has changed the definition of HCPCS E1010 power elevating legs from each to a pair but the price was not adjusted to reflect the change. There is no way we can provide these for the allowable on the fee schedule. Can this be addressed?

Comments concerning pricing should be sent to the DMERC pricing specialist.

18. Question: Medical policy states that "There is no separate payment for a headrest (HCPCS E0955 and E0966) on a captain's seat on a power wheelchair." Is a headrest separately reimbursable if the captain's seat is a FULL recline? Is a headrest separately reimbursable with a solid curved or specialty back?

A headrest on a captain's seat is not separately payable even if it is a full recline. A headrest is separately payable with other types of seating systems if medical necessity criteria are met.

19. Question: Our office is continually receiving COB17 or PRB17 (requested information not provided or incomplete) for the new Cushion and Back codes. These items don't specifically require a CMN. Why would they deny that way especially since a CMN is submitted with the wheelchair, and a majority of these claims have gone thru Advance Determination. We are also receiving CO18 denials (Duplicate claim/service) on the new HCPCS code E1028. Since it is dispensed with joysticks, headrests and lateral supports you may bill that three times with one wheelchair, and I do have notes in the HAO as to what item the E1028 is being used with. The incorrect denial of these codes by Medicare processors is causing a lot of extra work and more importantly is a great cost issue for our office and Medicare.

Still being researched.

20. Question: Our Office is trying to plan ahead for the new power wheelchair codes that will be effective Jan 1, 2006. How is Medicare going to handle advance determinations of the wheelchair, when an ADMC is submitted in December of 2005, but the chair is not delivered until after January of 2006? It is our understanding that the codes we bill separately for now will be bundled into just one code after Jan 1, 2006. Would our CMNs have to have pricing changes or code changes initialed and dated by the doctor? How would I submit the claim since the ADMC may have K0011 w/individual accessories approved or denied, but that would then become one code for all items requested?

Information concerning this process is not currently available. It will be addressed in a future supplier bulletin.

21. Question: HCPCS K0011 and Accessories—Our questions concerns repair of a HCPCS K0011, which in turn requires replacement of the batteries HCPCS E2365. The HCPCS K0011 required a CMN when the item was purchased, however the batteries only required an order. Do we need a new order stating frequency of replacement of batteries or do we just document reason for replacement, use modifier and no new order required?

There must be an order for the replacement batteries. It could be a single time order, or it could be an order which specifies an approximate frequency of replacement.

Ostomy/Urological/Medical Supplies

22. Question: We have several patients who receive over quantity catheters monthly for whom we have the LOMN to prove medical necessity—we receive an ADS letter and return it with the documentation and it gets paid—The next month we receive an ADS letter for the same patient--we send it in with documentation and it gets paid. Why must we send the exact same information each month?

You should not have to re-send the same information each month. Claim examples will be requested from the supplier for further research.

Diabetic Monitoring and Supplies

No questions submitted

Documentation/Regulatory/Miscellaneous

23. Question: The Minnesota Department of Health Services only has the capacity to read the first denial when several denial codes are listed for a claim line. Is it possible for DMERC Region B to list the most relevant denial code first, so that Minnesota Medicaid is able to process its portion of the claim more efficiently? This would help suppliers who are trying to pass along noncovered (ABN obtained) charges to the Medicaid payer.

The CMS has instructed the DMERCs to follow specific instructions and/or requirements for both paper and electronic remittance notices. The Standard Paper Remittance (SPR) is a product of the CMS standardization of the supplier payment notification. The SPR was created to provide a new remittance notice that is uniform in content and format as well as to help ease the transition to electronic remittance notice media. The DMERC does not have the authority to modify the paper or electronic format of the remittance notice.

The fact that another insurer decides not to provide secondary coverage based on a particular denial received by Medicare is not an issue the DMERC can resolve.

24. Question: Effective July 2005, Administrative Simplification Compliance Act (ASCA) enforcement begins requiring covered entities to file claims electronically. If additional documentation is required with the claim and this information will not fit in the narrative text field, must dealers wait for a letter from Medicare requesting the additional information? Will the DMERC implement a process to facilitate electronic and/or facsimile transmission of the additional documentation?

In the Region B DMERC March 2005 Bulletin an article was issued advising suppliers that the Region B DMERC Medical Review department has revised its procedures to permit suppliers to submit their claims electronically. If the Region B DMERC Medical Review department needs additional information, it will develop the claim to the supplier, requesting that information. At that point, the supplier may submit additional hard copy documentation.

Supplier should utilize the note segment of the electronic claim record to the full extent possible. The note segment is limited to 80 characters at the claim level or 80 characters at each line level. (If both the claim and line level information is submitted, the line level information will override the claim level information.) Suppliers are allowed to eliminate unnecessary words and abbreviations in the note segment field. However, in other circumstances greater amounts of information and/or copies of documents from the patient's medical record may be required. These situations will necessitate that the supplier wait for a development letter before submitting the additional documentation.

The new procedures indicated above were implemented due to the ASCA enforcement of mandatory electronic submission of Medicare claims, which is effective July 1, 2005. At this time, suppliers are instructed to follow these procedures for electronic claim submission to the Region B DMERC.

25. Question: With the ability to check enteral CMNs on the Interactive Voice Response (IVR) unit, suppliers are finding that the most recent CMN is not on file. CMN's that are submitted hardcopy are not getting updated. Suppliers will receive the correct payment for a claim so the supplier expects Medicare has utilized the CMN that was submitted hardcopy. However, the supplier learns they were paid from a previous supplier's CMN so the DMERC does not have the most current CMN on file. Suppliers feel they have fulfilled their obligation by sending the correct CMN and requesting it to be updated. How can suppliers be assured the most current CMN has been entered into the DMERC system?

The IVR unit can only identify CMNs when they have been accepted by the common working file. There are situations where Region B DMERC will accept the CMN, but the CMN was not accepted by the CWF. In this case, the CMNs will not report on the IVR unit. The Region B DMERC is currently working on enhancing the IVR unit to resolve this issue. Please refer to the AdminaStar Federal Web site (www.adminastar.com) for upcoming details on new enhancements made to the Interactive Voice Response (IVR) Unit.

The Region B DMERC External Affairs staff researched examples provided by the supplier. The results are listed below:

- **For the recertification CMN that the supplier provided as an example, the CMN initial date was not entered on the recertification CMN.**
- **For the two revised CMNs that were submitted as examples, both CMNs were missing the initial date also. Suppliers must enter the initial date as well as the revised or recertification date on the CMN. If an initial date on a CMN is not entered this will cause the supplier to receive a front end CMN rejection.**
- **On one of the initial CMNs received, the CMN should have been submitted as a revised CMN since Medicare already has an initial CMN on file.**
- **The last two initial CMNs received could not be researched due to the Medicare system not allowing research for dates that are not within the past three months on front end claim rejections.**

26. Question: When Medicare is the secondary insurance on a capped rental item and the primary insurance purchases the equipment on month four, what is the correct process for submitting claims to Medicare?

Medicare guidelines regarding payment/nonpayment of an item are consistent, regardless of whether Medicare is paying as primary or secondary. Without specific direction from CMS to do so, alteration of claims submitted to Medicare would be fraudulent.

27. **Question:** When Medicare is the secondary payer, is there a simple formula to follow to verify if reimbursement is correct?

40.7.3—Medicare Secondary Payment Calculation Methodology for Services Reimbursed on Reasonable Charge or Other Basis Under Part B

(Rev. 1, 10-01-03)

B3-3328.20.A

When a proper claim has been filed (i.e., a claim that is filed in a timely manner and meets all other filing requirements of the Group Health Plan [GHP]), the amount of secondary benefits payable is the lowest of the:

- Actual charge by the physician/supplier (or the amount the physician/supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the GHP;
- Amount Medicare would pay if services were not covered by a GHP. (In determining this amount, the payment limitations in the Medicare Benefit Policy Manual, Chapter 16, §50 and 50.1, for non-inpatient psychiatric services apply; and the payment limitations in the CMS IOM, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, section 60, for physical therapy services apply.); or
- Higher of the Medicare fee schedule or other amount that would be payable under Medicare (without regard to any Medicare deductible and/or coinsurance amounts) or the GHP's allowable charge (without regard to any co-payment imposed by the policy or plan) minus the amount actually paid by the GHP.

Also, Chapter 4, page 2 (Medicare Secondary Payer) of the *Region B DMERC Supplier Manual* includes examples for further clarification.

28. **Question:** Section C of the CMN is a free form space for the supplier to list the items/frequency/allowable price/retail price provided to the beneficiary. Can DMERC B suggest other information that a supplier can show on the CMN in Section C, above and beyond what is published in Chapter 18 of the Region B DMERC Supplier Manual? This would be helpful to the DMERC claims processors.

Section C should be utilized to include the information required in the detailed written order if being used as the detailed written order. Section C should not be used for other medical necessity information. It is required that suppliers complete this section before the CMN is sent to the physician. Satisfactory completion of Section C may be assessed in post payment audit situations, but is not reviewed by claims processors.

29. **Question:** According to the CMN completion section of the Medicare Manual: “The initial date in the section A should be either the specific date that the physician gives as the start date of the medical necessity or, if the physician does not give a specific start date, the initial date should be the date of the dispensing order.” Consider the following hypothetical example. The patient suffered a CVA, losing the ability to swallow, on December 25, 2004. They were admitted to the hospital, started tube feeding on December 25, 2004 and when they were well enough, transferred to the SNF on January 5, 2005 on a Part A stay (PPS). The Part A stay lasted until March 15, 2005. Supplier was asked to provide enteral nutrition to the now Part B qualified patient on March 15, 2005 and received a verbal dispensing order from the physician via the nursing facility. What should they show as the patient’s initial date on the CMN?

It would be appropriate to use March 16, 2005 as the Initial Date on the CMN.

Other

30. **Question:** Would Medicare pay on claims dispensed 27 to 29 days after the previous 30 day supply was dispensed. This would allow a three day overlap to suppliers dispensing a 30 day supply of medications, due to the 30th day falling on a weekend and or holiday.

Yes, the Region B DMERC updated system editing to allow for mail time when billing for HCPCS codes G0371 and G0374. This five day allowance accounts for holidays, weekends and months with less than thirty days. Please refer to the article titled “Pharmacy Dispensing Fee for Codes G0371 and G0374 Allowance of Mail

Time,” which was posted to the What’s New section of the AdminaStar Federal Web site (www.adminastar.com) on April 18, 2005.

31. Question: Please clarify the appropriate way to bill budesonide (HCPCS J7626) compounded with formoterol (J7699). The assumption is that it should be HCPCS J7626 KP and J7699KQ. What will be the reimbursement for formoterol?

In this situation, the budesonide (J7626) must be billed with the modifier KQ. The Nebulizer policy specifies that modifiers KP and KQ must be used so that the “combination...yields the lowest Medicare allowance.” The current allowance for HCPCS J7626KP is \$4.10 and for HCPCS J7626KQ is \$0.032. There is currently no established fee schedule amount for formoterol.

32. Question: When billing the HCPCS code J7699 the Medical Policy requires the supporting documentation be submitted with each claim month after month. When the patient will be using a J7699 product for an extended course of treatment, is it possible for the DMERC to refer back to the documentation submitted in prior months?

With each electronic claim, the name of the drug should be identified. However, additional medical necessity information does not have to be submitted each month.