Medicare Region B DMERC/Region B Council Frequently Asked Questions

Adams Mark Hotel – Indianapolis Airport
2544 Executive Drive
Indianapolis, IN 46241
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11:45 AM – 1:15 PM

Home Medical Equipment

1. Questions 6 and 7 of the Algorithm for MAE coverage for a Manual Wheelchair strongly imply that someone needs to visit and evaluate the patient's home to meet environment and safety considerations. Is this true, and if so whose responsibility does this fall under? I am assuming it would be the responsibility of the ordering physician's office, but is this correct?

   The supplier would usually be the one to assess whether the patient's home can accommodate the wheelchair that is ordered. For a manual wheelchair, this would not usually require an in-home visit. For a POV and power wheelchair, an in-home visit would generally be needed to make that assessment.

2. For Manual Wheelchairs, if we send the MAE Algorithm to the ordering physician, and all of the first seven questions are answered in such a way to qualify for the wheelchair, is this sufficient documentation to have on file along with the Wheelchair CMN, or is there more that is needed? If more is needed could you be specific about what that would be so we can attempt to comply?

   Simple yes or no responses to the questions in the algorithm would not be sufficient to document that the coverage criteria had been met. The documentation should identify the condition(s) that make the wheelchair necessary and pertinent elements of the patient's history and physical examination.

3. Doctor sends patient to our office with an order for a wheelchair. We go through the *Clinical Criteria for MAE coverage* and the patient does not qualify for the wheelchair per the algorithmic process to determine the level of MAE being ordered. Patient still wants the wheelchair and an ABN is signed stating that they did not meet the Clinical Criteria for the wheelchair. The CMN comes back completed by the physician and it looks as if they would qualify under Medicare Coverage Criteria as stated in Medical policy - how should we bill for this? We will bill with the GA modifier, but do we need to state in HAO note the *Clinical Criteria for MAE coverage* has not been met, or do we need to add an additional modifier as a warning to Medicare that patient may not qualify?

The ABN should describe why the supplier believes that the wheelchair does not or may not meet coverage criteria. There is no requirement that this be listed in the narrative field of the electronic claim. There is currently no modifier, other than the GA, that the supplier can use to indicate that the coverage criteria have not been met.

Enteral/Parentral/IV Therapy

4. The DMERCs provided CMN instructions for billing enteral formulas that had a HCPC change effective 1-1-05. Since then, there have been HCPC changes on other enteral formulas. Can the same CMN procedures be used for the other enteral formulas?

   Prosure:

   01/01/04: B4155
   01/01/05: B4150
   05/11/05:B4154

   Nutren Jr:

   01/01/04: B4150
   01/01/05: B4158
   04/15/05: B4160

   Resource for Kids:

   01/01/04: B4150
   01/01/05: B4158
   04/13/05: B4160

   Yes, suppliers should follow the general instructions described in the article on page 8 of the March 2005 Region B DMERC Supplier Bulletin, using the date of code change as the Initial Date and Signature Date of the new Initial CMN.

Respiratory Care Equipment/Oxygen Therapy

5. What is the quantity per month that can be covered for A4623 without our receiving an over utilization denial? A supplier needs to know when to obtain an ABN.

   There is no policy that describes utilization guidelines. Suppliers should use their knowledge of generally accepted practice to provide guidance on when to obtain an ABN.

6. If a patient has testing done in the Emergency Department and then is subsequently discharged home, can the results be used for qualification for oxygen since the patient condition would be considered stable at time of discharge?

   If the patient is seen in the Emergency Department for an acute respiratory condition, a blood gas study obtained during that visit does not meet criteria for coverage of home

oxygen because the patient is not in a chronic stable state and is not being discharged following an inpatient hospital stay.

7. Does the DMERC have any comment on the recent CMS directive regarding HMEs being permitted to obtain home oximetry to qualify home oxygen patients? Specifically, the instructions that the HME dealer can act "only as a courier" and cannot "instruct" the patient or "administer" the test. In the real world, these instructions are obviously ludicrous since the typical elderly patient who requires oximetry testing cannot/will not call or access a website at night for instructions, and written instructions only are very frequently inadequate. Demonstration of a clinical procedure prior to application is the accepted method of achieving compliance and quality outcomes.

   The DMERC has no comment on the instructions provided by CMS.

8. On page 11 of the oxygen policy, under "Recertification CMN is Required:", there is a section that states the following: "If a Group I patient with a lifetime length of need was not seen and evaluated by the physician within 90 days prior to the 12 month Recertification but was subsequently seen, the date on Recertification CMN should be the date of the physician visit." We have interpreted this to mean that if we have an initial oxygen CMN that is due to be recertified on 6/25/05, but the patient was not seen by the physician until 8/1/05, then the Recertification date would have to be 8/1/05. Since the initial CMN expires 6/25/05 and the Recertification did not occur until 8/1/05, then there would not be a CMN to cover dates of service between 6/25/05 and 8/1/05, therefore these claims would be denied for no CMN.

   However, page 6 of the oxygen policy, last sentence of the first paragraph states, "If the patient is not seen and re-evaluated within 90 days prior to Recertification but is subsequently seen, payment can be made for the dates of service between the scheduled Recertification date and the physician visit date if the blood gas study criteria are met." This statement is clearly saying that payment can be made for dates of service between 6/25/05 and 8/1/05, in the case of the example above, as long as the gas study criteria are met. So if this were the case, would we actually receive payment if we submitted the claims between 6/25/05 and 8/1/05 considering all other criteria is met? Or are we misinterpreting the policy? If we are misinterpreting the policy please use the example given to provide us with the correct way of handling this situation.

   Your understanding of the policy is correct. If the Recertification CMN is filed as described, payment will be made for claims with DOS between 06/25 and 08/01.

9. We have received guidance from industry consultants on how to properly bill for the respiratory medication compound of Budesonide and Formoterol. Before we bill the DMERC, we would like to determine if this is correct guidance for modifier usage per DMERC guidelines for the least costly alternative for the beneficiary:

   Formoterol J7699 with <u>no modifier</u> as the miscellaneous code will not accept a modifier.
   Budesonide J7626KP – The <u>KP</u> modifier must be used to denote that this product is compounded and compounded in conjunction with another product.

For this combination, the budesonide (J7626) must be billed with the KQ modifier. The Nebulizer policy specifies that the KP and KQ modifiers must be used so that the "combination…yields the lowest Medicare allowance." The current allowance for J7626KP is $4.178 and for J7626KQ is $0.014.

Prosthetics/Orthotics

10. How long may a supplier rely on a verbal order to dispense an orthotic assuming that the condition of the patient has not changed?

    As stated in the Therapeutic Shoes policy, the supplier must have a detailed written order prior to billing for an Orthotic to be paid. If the supplier does not have a detailed written order, the EY modifier must be added to the code. A written order for a therapeutic shoe insert is valid for one year.

11. When ordering and supplying a DMEPOS, may one physician sign the dispensing order and a different physician sign the detailed written order (i.e. when multiple doctors work in a group)?

    Yes.

12. When ordering diabetic shoes does the supplier need a verbal order along with the Statement of the certifying physician and the detailed written order?

    A statement of the certifying physician and a detailed written order is always needed. A separate verbal order is needed prior to dispensing only if the detailed written order is not obtained prior to dispensing.

13. Assuming you need a verbal dispensing order, may a pair of shoes be dispensed after receiving verbal order that demonstrates the presence of the coverage criteria for diabetic shoes but prior to receiving the signed statement of the certifying physician?

    Yes. However, if the supplier does not receive the statement of the certifying physician prior to submitting the claim, the KX modifier may not be used.

14. For diabetic shoes, may the statement of the certifying physician be included on the detailed written order? The 48 hour rule for O&P products - if the resident will be staying on at the facility not under Part A and to use the product for long time use does this rule still apply?

    Yes, the statement of the certifying physician may be included on the detailed written order. If diabetic shoes are provided within 48 hours prior to the date that a patient's Part A covered stay in a nursing home ends, they may be covered if coverage criteria are met and if the patient will use them during the subsequent non-Part A covered stay.

15. May the medical necessity of an orthotic be proven through such documents as the physical therapy notes, evaluations or other documents that were not created by the physician? IF so, is the physician required to review and sign the physical therapy notes, nursing notes,

restorative notes in order to use those documents as evidence of the medical necessity of the orthotic?

Notes, evaluations, and other documents from nonphysician medical professionals (e.g., physical therapists) may serve to document medical necessity for an item as long as the person is a Medicare provider or employed by a Medicare provider and does not have any financial relationship with the supplier. The physician is not required to review and sign those notes.

16. In the case that an orthotic is over 5 years old, and a new device is needed, is documentation needed justifying the replacement of the old product/ or is it treated like a new order?

    It is treated like a new order.

17. It is our understanding that patients meeting the coverage criteria for diabetic shoes may receive one pair each calendar year. Must the medical record include additional documentation demonstrating the reason for replacement of the previous years provided shoes - are diabetic shoes considered to have a reasonable useful lifetime of one year, thus no additional documentation?

    There is no need to document the reason for provision of a new pair of diabetic shoes in a subsequent year, as long as there is a new order and statement of certifying physician.

18. a. In the event of a probe review, in order to demonstrate medical necessity of an orthotic, are suppliers required to obtain and produce medical documentation that demonstrates the effectiveness of an orthotic after it is placed on the patient?

    No.

    b. How detailed does a verbal dispensing order need to be to be acceptable and a verbal order signed by the nurse (i.e. received at the time of order) sufficient during hearing and appeals or does the supplier need to produce the countersign dispensing order by the physician?

    A verbal dispensing order does not have to be detailed. The supplier should always be able to produce the detailed written order which has been signed and dated by the physician.

Rehab Equipment

No questions were submitted

Ostomy/Urological/Medical Supplies

No questions were submitted

Diabetic Monitoring and Supplies

No questions were submitted

Documentation / Regulatory / Miscellaneous

19. Some physicians use pad prescriptions that when copied or faxed, show "void or illegal if copied". Since we can accept faxed or copied prescriptions for purposes of a WOPD, is a prescription with this verbiage acceptable?

    Use of such an order sheet would not generally be acceptable.

20. We have been receiving requests for refund for dates of service when a patient was either in a nursing facility or in the hospital. How does this affect the 15 month rental period for patients that are on maintenance and service?

    Example 1: If a patient takes the purchase option, we have billed and been paid for 13 months. Then we receive a request to refund one month because the patient was in the hospital. Should we bill one more month to actually cover a total of 13 months that were billed and paid? If we don't, your records will indicate a total of 12 months that were billed and paid and it will cause problems for any repair or replacement parts that are billed in the future because your records will still indicate a rental since only 12 months were billed and paid.

    If the Part A Service has the same dates of service (DOS) as the rental payment (06/01/05 thru 06/30/05) a new rental month should be billed. If the Part A service falls within a rental period, the date of discharge should be billed.

    Example 2: If a patient is already on maintenance and service and we receive a request for a refund. If we bill Medicare for what we consider to be the 28th and 34th month of maintenance and service and we receive payments for those months then if Medicare requests that we refund the 28th month because the patient was in the hospital and we have also billed the 34th month of maintenance and service and it too has already been paid that is going to cause the months to be off. To correct the records and bill for services that we are entitled to, would we re-bill the 28th month as the date of service that the patient was discharged from the facility and then also refund the 34th month of maintenance and service that was paid and re-bill the claims once the refunds have been processed.

    This situation requires claim examples.

21. At a recent Region B Spring 2005 Seminar, we were told all items sold to a Medicare Beneficiary, unless listed as statutorily exempt by Medicare, must be submitted to Medicare even if the Medicare beneficiary <u>specifically requests</u> it not be and wants to pay privately. We believe this information is incorrect as the beneficiary should have the right to decide if they want an item billed to insurance or not. Is this something which has changed recently? When it was mentioned at the Seminar a lot of people were upset and disagreed with the reasoning.

Before delivering any service, providers must decide which one of the following three conditions apply in order to properly inform Medicare beneficiaries as to their potential liability for payment according to notice requirements explained below:

CONDITION 1	CONDITION 2	CONDITION 3
Services are statutory exclusions (ex., not defined as part of a specific Medicare benefit) and billed as noncovered, or billed as noncovered for another specific reason not related to §1862(a)(1) and §1879 of the Act (see below)	**A reduction or termination in previously covered care, or a determination of coverage related to §1862(a)(1), §1862(a)(9), §1879(g)(1) or §1879(g)(2) will require a liability notice (i.e., ABN) OR a beneficiary requests a Medicare determination be given for a service that MAY be noncovered; billing of services varies**	**Services billed as covered are neither statutorily excluded nor require a liability notice be given**
Potential liability: Beneficiary, as services are always submitted as noncovered and therefore always denied by Medicare	**Potential liability: Beneficiary, subject to Medicare determination, on claim: If a service is found to be covered, the Medicare program pays**	**Potential liability: Medicare, unless service is denied as part of determination on claim, in which case liability may rest with the beneficiary or provider**

Note: Only one of these conditions can apply to a given service. The aforementioned information can be found in the CMS Internet Only Manual System, Publication 100-04, *Medicare Claims Processing*, chapter 1, section 60.1.1

Chapter 8, Claim Submission, page four of the *Region B DMERC Supplier Manual* states: OBRA 89 requires a Medicare provider to submit a completed claim within one year when furnishing covered items to a Medicare beneficiary. The provider is relieved of this obligation, and may perform a cash transaction when furnishing [statutorily] noncovered items, unless the beneficiary requests Medicare payment/determination. If the beneficiary chooses to waive Medicare determination/payment on Medicare covered items, the supplier is relieved of the responsibility to file claims for covered Medicare items. Should the beneficiary change his/her mind in the future, the requirement to file the claim would again be in force. If the patient chooses to waive the right to have Medicare billed, it would be advisable, not required, for the supplier to have written documentation of this in their records.

22. We understand there are many changes underway that will significantly change appeals processes including new requirements of Medicare contractors for first appeal level, establishment of Qualified Independent Contractors, and transfer of ALJs to HHS. These include responsibilities of involved CMS contractors and procedures for providers and suppliers. Included are rules regarding at what level of appeal a supplier can submit new documentation. Given the immediacy of these changes underway, what education is going to be provided to suppliers and when? Also, will new documentation be accepted from the supplier for the "Reconsideration" hearing (this is today's Fair Hearing) and beyond?

    Due to the Benefits Improvement and Protection Act of 2000 (BIPA), section 521 and the Medicare Prescription Drug Improvement and Modernization Act 2003 (MMA), section 931-940 these revisions will allow Medicare to implement a uniform appeals process for both Part A and Part B Medicare.

    The Benefits Improvement and Protection Act of 2000 (BIPA), section 521 will establish Qualified Independent Contractors (QICs) to conduct the 2nd level of appeals, which will be known as Reconsiderations. The Medicare Prescription Drug Improvement and Modernization Act 2003 (MMA), section 933 requires the appellant to submit all relevant evidence at or before the QIC Reconsideration level, which is currently known as Fair Hearings. If the appellant chooses to file an Administrative Law Judge (ALJ) new evidence or documentation for the claim in question will not be accepted. Also, effective June 30, 2005 all Administrative Law Judge requests with decision dates on or after June 24, 2005 the Social Security Administration has forwarded these requests to the Department of Health and Human Services (DHHS). The jurisdiction for an ALJ request is based upon the appellants address.

    The AdminaStar Federal Region B DMERC External Affairs staff will continue to provide education to the supplier community as these changes take place via the AdminaStar Federal Web site (www.adminastar.com), List Serve and during all seminars. For additional upcoming changes regarding timeframes, guidelines and new requirements of the appeals process please refer to the Medicare Prescription Drug Improvement and Modernization Act 2003 (MMA), section 931-940 and the Benefits Improvement and Protection Act of 2000 (BIPA), section 521.

23. How long we must keep proof-of-delivery documents has been discussed a number of times. We have a question regarding Imaged copies of delivery tickets. Technology allows us to scan the original into an electronic file cabinet and could be reproduced if an audit were conducted. Are there specific rules in regards to imaged copies of delivery tickets?

    Chapter 15 of the *Region B DMERC Supplier Manual* instructs maintaining Proof of delivery documentation for seven years. Chapter 15 does not instruct on scanned images. If this instruction becomes available it will be added to the manual.

Other

24. Electronic Billing Issues: In accordance with your 7/1/2005 requirements to bill all claims electronically, we are experiencing the following problems:

Bill for denial and non-assigned claims are being front end rejected for invalid procedure codes and/or modifiers. We know that they are valid according to CMS guidelines. The claims should be accepted regardless and denied on the back end if applicable. Non-assigned claims have the non-assigned indicator and bill for denial claims have the GY modifier.

Answer: We are not aware of any claims being front end rejected incorrectly with the invalid procedure code and/or modifier edit. Specific examples are needed to research further. Note: Claims sent with the GY modifier can only be sent as stated in the medical policy. When billing with a GY modifier for denial, a supplier must continue to follow the Medicare billing and policy guidelines.

If a patient does not qualify for oxygen coverage and we are billing for denial, there is no way to send CMN information electronically due to your edits. If the claim has the GY modifier or is non-assigned it should be accepted.

Answer: Specific examples are needed to research further. When billing Oxygen, the claim needs to be sent with the CMN and we will determine if the patient qualifies. If an Oxygen claim is sent without a CMN, a CO B17 denial will be received.

We have patients who request we bill a wheelchair purchase claim non-assigned and when billing electronically, the DMERC front end rejects the claim because it does NOT expect CMN data to be sent. How are we supposed to bill these types of claims electronically if the customer wants the CMN data sent with the claim?

The CMN is required for certain HCPCS codes. If the CMN is not required, it will reject on the front end. The CMN should only be sent if required by Medicare; the customer would not determine whether a CMN can be sent.

We have a patient with an oxygen saturation of 91 who cannot be taken off of oxygen for qualification testing. When we send you this CMN data electronically it gets front end rejected with the following error:

40097 OXYGEN TEST FINDING CODE MISSING 2400.
CR511
If CR511 > 88, an Oxygen Test Finding Code (CR513, CR514, or CR515) must be present

Because a CMN states “IF PO2 = 56-59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.” the doctor has not completed CR513, CR514 or CR515. We do not transmit data that is not on the CMN. How can this type of claim / CMN be accepted electronically?

Currently this is an issue within the VIPS processing system. These claims cannot go electronically when the oxygen saturation is above 89% and the facility information is not on the paper CMN. This problem has to be changed in the ANSI format and can not be changed prior to Version 5010. Per the current 4010(A1) Implementation Guide, Questions 8-10 have to be present if Question 7 is in the specified range. In order to continue billing these claims on paper, an ASCA waiver request should be sent.

Information on the ASCA waiver process can be found at www.adminastar.com, select DMERC, then ASCA.

25. For ongoing documentation for support surfaces, can the provider contract with an outside home health agency to do their wound care assessments? Or can provider-employed RNs and/or LPNs do wound assessments for the supplier's patients and will that documentation be considered in post pay audit for proof of medical necessity?

    Documentation of medical necessity provided by a person or entity with a financial relationship with the supplier would generally not be acceptable.

26. When DMERC B receives an electronic claim from a provider which is determined to be for a beneficiary from another DMERC region, does DMERC B forward the electronic claim to the correct DMERC for processing?

    When AdminaStar Federal receives an electronic claim from a supplier and the beneficiary address is outside of our Region, that claim will be forwarded electronically to the appropriate DMERC. The transfer of this claim is shown on the electronic front end report under the "TX" column. In this column it will show the Region where the claim was transferred.

    If AdminaStar Federal receives an electronic claim from a supplier and the beneficiary's address is in our Region, the claim then goes into the processing system. Once in the processing system, if it is determined through CWF that the beneficiary resides outside of Region B, the claim will be denied. The supplier may resend that claim electronically with the appropriate address (beneficiary address outside of Region B) and that claim will be forwarded electronically to the appropriate DMERC.

27. Can DMERC B print the "DBA" name of a supplier on the remit rather than the corporate legal name? The NSC is stating that this information can be communicated to the DMERCs for use on remits.

    The National Suppliers Clearing House (NSC) updates all Supplier information for all four DMERC Regions. The NSC does maintain Supplier "Doing Business as Name" information in their records. The DMERC Processing system is currently not equipped to receive this information from the NSC. The Centers for Medicare and Medicaid Services (CMS) would have to initiate a change request to have the current DMERC processing system updated to allow for this information to be transmitted.