Region B Council A-Team Questions
December 2005

Home Medical Equipment

1. Two different MAEs are ordered on the same date of service, because each helps the patient accomplish different MRADLs. Are they going to cover both whereas in the past one would have been denied? (For example: wheelchair helps them to get around in the kitchen for meal activity. Quad cane or walker helps them in the bathroom with grooming and hygiene.

   More than one type of equipment could be covered at the same time if they met different patient mobility needs in the home.

2. How would it be possible under the new NCD Guidelines for a patient to qualify for both a wheelchair and a walker? (i.e., when the patient has a short term rental w/c following a stay in a rehab hospital, would the patient be able to qualify for a walker as well?)

   See response to question #1.

3. If we dispense equipment to a patient and they lose the equipment – who is responsible for the replacement of that equipment – the patient, Medicare, the provider?

   The CMS IOM, 100-2 Medicare Benefits Policy Chapter 15, §110.2(C) Repair, Maintenance, Replacement, and Delivery states "Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this section. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood). A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item". In the event that the equipment is lost, the provider can replace the equipment and submit a claim to Medicare with proper documentation for reimbursement.

   For additional information on Repairs or Replacement of DME, please reference the article titled "Repairs and Replacement of DME" in the September 2003 Region B DMERC Bulletin, pages 5 & 6.

4. If we dispense 5 oxygen tanks to a patient and they lose two tanks, can the patient be financially responsible for the tanks lost?

   The CMS IOM 100-2 Medicare Benefits Policy, Chapter 15, §110.2 Repair, Maintenance, Replacement and Delivery states that charges for the replacement of oxygen equipment, items that require frequent and substantial servicing or inexpensive or routinely purchased items which are being rented are not covered. It would be a best practice and the responsibility of the supplier to advise the patient via the initial rental agreement that in the event of the oxygen

tanks being lost, maliciously damaged, culpable negligence, or wrongful disposition of equipment, that Medicare will not pay for the replacement and that the patient will be held financially liable.

5. If a patient abuses the rental equipment due to negligence can they be charge replacement value of the equipment?

   The CMS IOM 100-2 Medicare Benefits Policy, Chapter 15, §110.2(C)-States that for cases suggesting malicious damage, culpable negligence, or wrongful disposition of equipment should be investigated and denied where the DMERC determines that it is unreasonable to make program payment under the circumstances. DMERCs refer such cases to the program integrity specialist in the RO. It would be a best practice and the responsibility of the supplier to advise the patient via the initial rental agreement that in the event of the oxygen tanks being lost, maliciously damaged, or in the event of culpable neglect, or wrongful disposition of equipment, that Medicare will not pay for the replacement and that the patient will be held financially liable.

Enteral/Parenteral/IV Therapy

6. When an IV pole is rented for use with an external infusion pump, what payment category is it paid under? Is it Inexpensive/Routinely purchased, capped, or continuously rented as long as it is medically necessary? Same question for an IV pole for use with an enteral or parenteral pump.

   This question is being researched by the Region B DMERC Pricing Specialist, and an answer will be communicated via list serve upon completion of the research.

Respiratory Care Equipment/Oxygen Therapy

7. Oxygen and Medical Policy: "The patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any Recertification. If the patient is not seen and re-evaluated within 90 days prior to Recertification but is subsequently seen, payment can be made for dates of service between the scheduled Recertification date and the physician visit date if the blood gas study criteria are met." The policy goes on to say "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." This seems to contradict itself. If the recert date is the date of the physician visit, and is past the 12 months, and also past the 90 days, how can we get paid for the days between (after the 12 months expired, but before the "Recert/90 day eval" date)? Please clarify?? Also, please clarify; these patients do not need to be retested as long as their initial CMN length of need was 99…correct?

   Payment can be made for dates of service between the scheduled Recertification date and the physician visit date if the blood gas study criteria are met. Patients meeting the Group 1 criteria are not required to retest if the initial blood gas study was performed prior to the 13th month of therapy and the length of need indicated on the initial Certificate of Medical Necessity is lifetime. If the length of need on the initial Certificate of Medical Necessity is less than lifetime for a patient meeting Group 1 criteria, a repeat blood gas study is required in order to extend coverage.

8. We have a patient that is in the VA and is on oxygen. They are leaving the VA facility and dropping their VA benefits. They will be Medicare Primary. Will the VA doctor be acceptable as the prescribing physician and will the testing done in the VA be considered an acceptable testing facility to establish that they meet the Medicare criteria for home oxygen?

   Yes, a VA physician would be considered an acceptable ordering physician and the VA facility would be an acceptable testing site.

9. The current DMERC Region B Manual in Chapter 17 Medical Policy NEB-20 States "Disposable large volume nebulizers (A7007 and A7008) are non-covered under the DME benefit because they are convenience items. A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the patient/caregiver is an acceptable alternative."

   The problem is that per CMS, no product matches nebulizer code A7017 and the code E0585 includes code A7017 that does not exist.

   While the medical policy states the therapy is a benefit, the items to provide this therapy either don't exist or are not billable. In essence the benefit has been eliminated.

   Can Region B please comment or give suggestions on this issue?

   This issue is being researched with the other DMERCs and the SADMERC.

10. A patient has a BiPAP S but only qualifies for a CPAP (all coverage requirements met except it has not been ruled out that a CPAP has been tried and failed). The RAD policy states they will down code the machine. How would the supplies be billed – with a KX modifier or without?

    In that situation, if the supplies were items that could be used with a CPAP or RAD, the KX modifier would be used on the supplies. The KX modifier would not be used on the code for the RAD itself.

11. An oxygen saturation taken during ambulation, is that classified as at rest or during exercise? Please clarify what is “at rest”.

    An oxygen saturation taken while a patient is ambulating would be considered “during exercise”. “At rest” would be a test taken when the patient is awake and either seated or in bed.

Prosthetics/Orthotics
No questions

Rehab Equipment

12. We are a for-profit homecare company with DME owned by a health system that also owns a hospital. Can the hospital PT's and OT's perform functional evaluations per the new MAE policy? Can our own

homecare PT's and OT's perform these evaluations? Are the evaluations billable by the PT's and OT's to Medicare B?

Evaluations conducted by hospital-employed PTs or OTs who saw the patients in the hospital facility could be considered to be a part of the statutorily required face-to-face examination. However, evaluations conducted by PTs or OTs employed by the homecare company could not be considered to be a part of the statutorily required examination. Questions concerning billing for services performed by PTs or OTs need to be addressed to the fiscal intermediary or local carrier.

13. Are there any special requirements for qualifying a patient for Transport or Geriatric chairs?

Coverage criteria for a transport or geriatric chair would be same as those for manual wheelchairs as described in the Mobility Assistive Equipment National Coverage Determination and in the DMERC LCD on Manual Wheelchairs.

14. Now that it APPEARS that the IFR will be postponed until April, under what guidelines should I be operating today? My concern is for post pay audit. How will CMS and the DMERCs ever remember what guidelines were in effect for what dates, and how will they review claims from this time period 3-5 years from now?

The IFR went into effect for claims with dates of service on or after October 25, 2005 – with the exception of those identified as falling into the grace period described in the News article posted on the ASF DMERC Web site on November 7. Nothing has happened since then to change that. If there are any changes in the future, the DMERCs will address the issue at that time.

Ostomy/Urological/Medical Supplies
No questions

Diabetic Monitoring and Supplies
No questions

Documentation/Regulatory/Miscellaneous

15. We recently received a denial on a maintenance charge for a piece of capped equipment that had been on rent longer than 5 years. When we called to inquire about the denial, we were told by customer service that since the patient had exceeded the 5 year limit for capped equipment we should begin billing a new capped period. Is this information correct? Should we monitor rentals and initiate a new capped period or wait for a denial?

Maintenance and Service denials should never be given based solely on a five year period. Claim examples can be forwarded for research. Medicare will deny maintenance and service capped rental claims only if the maintenance was billed prior to 6 months after the end of the fifteenth paid rental month or paid maintenance. Medicare's Reasonable useful lifetime for capped rental equipment is five years. If a capped rental item of equipment has been in continuous use by the patient, on either a rental or purchase basis, for the equipment's useful

lifetime or if the item is lost or irreparably damaged, the patient may elect to obtain a new piece of equipment. Medical necessity criteria and Medical policy claim submission standards must be followed in order for the supplier to submit the claim to Medicare.

16. Will Medicare accept paper claims for break in service if billed with the "break in service/break in billing form" we received in a list serve?

    The Break in Service/ Break in billing form can be found on the AdminaStar Federal Web site under Provider Specific Information/Forms. A Listserv Article posted on 09/23/2005 in the What's New section of the AdminaStar Federal Web site explained that the electronic Break in Service claim submission procedures will be communicated when they become available.

    Note: New ASCA compliant Break in Service submission procedures were posted to the ASF Web site and sent out on the ASF Listserv on 12/7/2005. These procedures will become effective January 1, 2006.

17. What date do we put in the HAO record for repairs to a wheelchair that the patient took the purchase option on? Do we use the initial date of service or do we use the last rental date that was billed to Medicare (which would be the purchase date)?

    When billing for repairs to a wheelchair, the initial date is the appropriate date to record in the narrative record.

18. Is there specific wording needed in the HAO record for MPO's whether BP or BU response?

    Standard language has not been established for the narrative record. The patient's election to purchase or continue renting should be indicated by the BP, BR or BU modifier attached to the HCPCS code.

19. We sent an Advanced Determination that had all of the information that would be on a CMN, but Medicare requested a copy of the CMN (no signature required). My understanding is that we don't need to produce a hard copy CMN at all. We only need to submit electronically a partially completed CMN so the claim will process correctly until Medicare fixes their system to accommodate the elimination of the CMN. Why are we being asked for a copy of a CMN?

    For ADMC requests, the DMERCs need the partially completed CMN to enter needed information about the patient (from Part A of the CMN) into the system. Instructions about ADMC requests were published in a News article posted on the ASF DMERC Web site on November 8. This information is also included in a revision of the ADMC chapter in the December Supplier Manual update.

20. If Medicare is going to pay based on the prescription, what is the point of the ABN? When would we ever truly expect a denial? For example, we determine the patient does not meet criteria for a scooter and the patient is willing to pay cash but still wants us to bill. When we get paid, we need to refund the money to the patient but we're still subject to a post payment audit and refund due to insufficient supporting documentation of medical need. Another example is another payer such as Passport

requiring us to bill Medicare first. If we can't show them a Medicare denial, they won't pay for it even though they want the patient to have it. Our only ability to manage this is to not provide the equipment.

An Advanced Beneficiary Notice would be required in any instance where the supplier has determined that Medicare may deny the service being rendered due to lack of medical necessity. In the scooter scenario above, if the beneficiary has paid for the item the claim should be submitted to Medicare with the paid amount indicated. In the event of Medicare payment, the beneficiary would be reimbursed. This will ensure that the Medicare payment will be sent to the proper recipient. When incorrect denials are received for services rendered, the supplier has the right to request redetermination of the claim. However, please be mindful that non-covered denials are not given upon request. The items being billed must be excluded from benefits in order to receive a non-covered denial. If the Medicare Program has a provision in place to cover a particular item and the patient does not meet the coverage criteria, the claim may be denied as not medically necessary thus requiring an ABN to hold the beneficiary liable. This may result in a CO category denial instead of a PR category denial.

21. My main question/concern is whether Medicare will have a problem with wheelchair CMNs which have both Section's A and C filled out due to programming in providers software packages. In the instructions provided by the DMERCs, it says hardcopy CMNs are to have only Section A filled out but I'm just wondering if that should be read "Only Section A is required". I can't imagine a rejection based on too much information existing on the CMN, especially since the phase-out process should be aimed at trying to ease the changes in and not require immediate changes by everyone. Can Section C be filled in or must it be left blank?

    Section C of the CMN may be filled in.

22. What type of documentation will be needed in a provider's charts for canes, crutches, walkers, and manual wheelchairs? Are you looking for pages of progress notes from the physician's records to be given to use for a cane, crutch or walker? The documentation needs are clearly spelled out for the power mobility so additional guidance for the lower end mobility items would be much appreciated.

    The extent of the documentation depends on the complexity of the equipment that is provided. For common canes, crutches, and walkers, there would need to be information about the diagnosis relating to the need for the device and the problem(s) that it was addressing – e.g., balance, weakness, pain, etc. For manual wheelchairs, there must be similar information plus documentation indicating why a cane or walker won't meet the patient's mobility needs in the home and that the patient will be using the wheelchair on a regular basis in the home.

Other
No questions