



Region B Council A-Team Questions Sorted by A-Team

Disclaimer: The Region B Council A Team Participants have provided the following questions. The answers and references cited are correct as of the publication date.

Please note: As of March 1, 2006, TriCenturion assumed Program Safeguard Contractor (PSC) responsibility for the Region B DMERC. PSC responsibilities include Medical Policy, Medical Review, and Benefit Integrity. Questions/Answers pertaining to the PSC responsibilities are subject to TriCenturion's interpretation. Please refer to our website www.adminastar.com, TriCenturion's website www.tricenturion.com or visit the centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov for recent updates.

Home Medical Equipment

1. We are considering purchasing a company that has a population of nebulizers for which no purchase option letters were sent. If we purchase the business, what will be required of us to correct the problem? Can we send out a purchase option letter at this time? We know this is not typically allowed, but we want to make sure that we take necessary steps to mitigate the problem. Please let us know what you would advise.

The Region B DMERC Supplier Manual, Chapter 2, Supplier Enrollment, page 4 states:

CHANGE OF OWNERSHIP

The DMEPOS Supplier Enrollment Form (CMS-855S) defines a change of ownership as:

- **In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law;**
- **In the case of an unincorporated sole proprietorship, transfer of title and property to another party;**
- **In the case of a corporation, the merger of the supplier corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the supplier corporation does not constitute a change of ownership); and**
- **In the case of leasing, the lease of all or part of a DMEPOS supplier facility constitutes a change of ownership of the leased portion.**

When there is a change of ownership, a new supplier number must be issued unless the new owners assume all liabilities and the tax identification



number of the existing supplier. Otherwise, the existing supplier number may not be used by the new owner. The new owner must submit the CMS-855S form to the NSC within thirty (30) days of the change of ownership, along with a bill of sale, articles of incorporation filed with the state, and any other documents that show the exact nature of the transaction.

The outgoing owner must notify the NSC in writing over the signature of an authorized representative that they are not the owner of record as of the date of the change of ownership. The old supplier number will be inactivated. If all requirements are met, the new number will be effective from the date of the change of ownership. Claims for items furnished between the date of the change of ownership and the issuance of the new supplier number may be submitted to the DMERC once the supplier has received the new number.

In the scenario described above, the new owner must make a business decision as to whether or not they will assume all liabilities and the tax identification number of the existing supplier. If the new owner assumes all liabilities and tax identification number of the existing supplier, a purchase option must be sent to the beneficiary and if the beneficiary elects to purchase the equipment, a refund would be due to the Medicare Program for all of the excess rental payments and maintenance and servicing payments paid after the 13th month and the files must be documented as to why the patients were notified after the 10-13th rental.

If the new owner does not assume all liabilities and the tax identification number of the existing supplier, the new owner does not have any obligation to the existing patients. The existing supplier would need to make a business decision as to how the existing patients and their DME will be handled and reported to CMS. For additional information please visit the CMS Web site at: <http://www.cms.hhs.gov/Manuals/PBM/list.asp#> .

- 2. In regards to the five-year rule for replacement of worn out equipment, if the item was purchased through the capped rental process, does the five years start from the date the equipment was delivered to the patient or from the date it caps as purchased? Also, if the time period has been over five years, is it necessary to document to Medicare what the specific problems are with the old equipment that necessitate replacement?**

LENGTH OF REASONABLE USEFUL LIFETIME §1834(a)(7)(C)(iii) of the Social Security Act states: The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.



Calculation of useful lifetime for durable medical equipment begins from the date the equipment is delivered to the patient plus five years.

The Region B DMERC Supplier Manual Chapter 14, Pricing and Overpayments on page 13, states the following:

Replacement of Capped Rental Equipment:

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. Payment for replacement capped rental equipment will be made in accordance with the guidelines on pages 5–7 of this chapter, or, if an electric wheelchair, in accordance with the guidelines on pages 8–9.

If a new piece of equipment is being delivered after five years it is not necessary to document the condition of the old equipment. If the new equipment is being delivered within the five year period the RP modifier is required to be submitted along with a narrative explaining the reason for the replacement. Please refer to the Region B DMERC Supplier Bulletin article, "Repair and Replacement", published September 2003, pages 5-6.

3. We received a list serve saying to submit Break in Service claims electronically with notes in the NTE field that this is a BIS claim and why. We are beginning to see claims denials, and customer service is telling us to go back to submitting BIS claims hard copy. What should we do?

Per the ASCA provision and the Region B DMERC list serve message below dated December 9, 2005, Break In Service (BIS) claims must be submitted electronically. Since a BIS is defined as a substantial change in the patient's medical condition that would warrant significantly different equipment, there are many reasons why a BIS claim could be denied without proper documentation on the electronic claim (NTE – Note segment) If a denial is received on a BIS claim, please refer to your remittance advice for appeal procedures.

When submitting Break in Service claims electronically, suppliers should follow the instructions listed below.

Submit the following information in the Note Segment (NTE) in the order and format as follows:

Order:

1. The abbreviation "BIS" for Break in service.



2. The “pick up” date and the “delivery” date. (MMDDYY) 3. The beneficiary’s previous diagnosis (ICD-9 code) and the new diagnosis (ICD-9 code).

Format:

BIS MMDDYY MMDDYY ICD-9 ICD-9

Example:

BIS 100105 123005 379.31 V43.1

Certificate of Medical Necessity (CMN):

Transmit the new CMN if necessary

The Note Segment (NTE) is limited to 80 characters at the claim level or 80 characters at each line level. If both claim and line level information is submitted, the line level information will override the claim level information. If additional documentation is needed or if the new CMN cannot be transmitted, AdminaStar Federal will develop the claim and request the additional documentation.

4. If a beneficiary does not qualify for a wheelchair using the MAE Algorithm, how should the CMN and claim be sent electronically? Because there are no edits in place for coverage, a claim for a wheelchair will be automatically approved. Should the GA and GY modifiers be used to indicate that the beneficiary does not qualify?

The CMS Manual System, Pub. 100-3 Medicare National Coverage Determinations, Chapter 1, §280.3 (C), Mobility Assistive Equipment (MAE) states that for Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined above, and as documented by the beneficiary’s physician, would not be eligible for Medicare coverage of the MAE. Suppliers are instructed to submit claims for patients not meeting the coverage criteria with a GY. The GA modifier can be added if the supplier has provided the patient with an Advanced Beneficiary Notice, which specifically addresses why Medicare will not allow for the MAE provided.

5. When a patient qualifies for a manual wheelchair per the MAE Algorithm but their disease (such as ALS) indicates that there will be a future need in the next 6-12 months for a power wheelchair, will Medicare consider the power wheelchair today?

The IOM-Pub 100-3 Medicare National Coverage Determination Chapter 1, §280.3 Mobility Assistive Equipment (B) Nationally Covered Indications, states:

“Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.”



Currently there are no provisions under the Medicare Program to allow for DMEPOS items for future use when the patient has been diagnosed with a progressive neurodegenerative disease. Based upon the above referenced IOM, the purchase of a power wheelchair will be considered when there is clinical evidence to support the medical need.

Enteral/Parenteral/IV Therapy

6. We have received several denials for B4036 (Gravity Feeding Kit) stating that the claim lacks information which is needed for adjudication (PR-16). When we call, we are told that the narrative field must state that the patient either owns or rents an IV pole. Why is it necessary that a patient owns or rents an IV pole when there are other less costly alternatives than an IV pole? Is there an edit in place that requires this narrative and is this a new requirement in the Enteral policy?

Claim examples will be reviewed.

7. Enteral formula and kits have been denying when the date of service overlaps by one or two days from the previous delivery. Per the January 22, 2004 Medicare Updates Webinar FAQ question #6, it is acceptable to have dates overlap up to 5 days to ensure timely delivery of supplies. What can we do to prevent future denials for overlapping dates?

For subsequent deliveries of refills, the supplier should not deliver the item and/or supplies no earlier than five (5) days prior to the end of usage for the current product; irregardless of what delivery method was utilized. The date of service on the claim for refills could actually be the start date of the “new” usage period and if so, this date should not overlap the previous usage date. For additional information please visit the What’s New section of the AdminaStar Federal Web site (www.adminastar.com) and reference the article titled “Clarification of Proof of Delivery Requirements”, which is dated January 13, 2004.

Respiratory Care Equipment/Oxygen Therapy

8. The initial oxygen CMN for a high liter flow patient has a length of need of 12 months. The patient is required to be retested to determine if he/she still requires oxygen. Since the patient is HLF, does the patient have to be retested on room air and on 4 LPM in order to continue to qualify for HLF reimbursement?

When recertifying a patient who initially qualified for HLF, it is not necessary to retest the patient on both room air and on 4 LPM. A repeat blood gas study must be performed while the patient is on 4 LPM to determine if the patient still qualifies for HLF oxygen. Please refer to the Oxygen and Oxygen Equipment medical policy, which is located in the Region B DMERC Supplier Manual, Chapter 17, on page 5 for additional information.



9. In the course of reviewing patients' accounts, we would occasionally identify that we had billed inappropriately with a KX modifier for CPAPs and RADs on the fourth and subsequent months without getting the appropriate documentation before the claims were billed. The required documentation was subsequently obtained and the ongoing claims moving forward are being billed appropriately. What would be the course of action to take, if any, to rectify the billing error that ensued?

The documentation requirements for Respiratory Assist Devices (RAD) and Continuous Positive Airway Pressure Devices (CPAP) state that the KX modifier must not be used on claims submitted to the DMERC until the required documentation has actually been obtained and entered into the supplier's files. We suggest submitting a voluntary refund. The Region B DMERC Supplier Manual Chapter 14 outlines instructions for submitting Voluntary Refunds.

10. Recently we have received several CO B17 denials for oxygen patients that have come to us from other regions. When checking the IVR - it states that there are oxygen CMNs in the Common Working File, however, when we talk to the customer service reps, they don't see the CMN and they are telling us that we need to get a copy of the CMN from the other company and submit it with our claim. (We are still getting a CMN for our records.) When sending claims electronically, we cannot send another company's CMN. Other reps are telling us to add an HA0 record to the claim stating "previously serviced in Region C, please see Common Working File". We have done this, and the claims still deny. When we call, the reps are able to see the HA0 record but can't help us with getting the claims processed. What do we need to do?

Suppliers who are experiencing the situation indicated above should resubmit their claims for payment consideration. Processing procedures have been established for CWF review of oxygen CMNs. Please refer to the Region B DMERC September 2003 bulletin, page 3 for Oxygen CMN scenarios. In particular, please review scenario 5, 10, and 11 which will address the supplier requirements in case of an acquisition.

11. Patient-owned Bipap was purchased through private insurance in April 2003. The equipment is in need of extensive repairs. Now the patient is Medicare primary. Because this equipment was purchased by private insurance, will Medicare begin a new cap rental period or does the five-year rule apply?

Medicare's reasonable useful lifetime guidelines do not apply to DMEPOS items purchased prior to the patient becoming entitled to Medicare benefits. However, the documentation requirements specified in each individual medical policy must be met in order for Medicare to allow for the rental or purchase of a new DMEPOS item. Please refer to the Region B DMERC Supplier Manual, Chapter 17 for additional information.

12. Is there a conflict/duplication in equipment when dispensing Nebulizer (E0570) and an air compressor (E0565) to a patient at the same time?



It may be medically necessary for a small volume and a large volume nebulizer/compressor to be dispensed at the same time due to the medical need of the beneficiary. An ICD-9 code describing the condition which necessitates nebulizer therapy must be included on each claim for equipment, accessories and/or drugs. Please refer to the Region B DMERC Supplier Manual, Chapter 17, Nebulizer Policy for additional information.

13. When a patient switches from a Medicare HMO to fee for service Medicare for oxygen services and there is no break in service, we do not need to have them re-tested. Could we use the electronic break in service process? Is there a particular format you would like followed? Currently we submit these, you deny them and we need to review them with the CMN.

The Region B DMERC Supplier Manual states “there is an exception for patients who were on oxygen in a Medicare HMO and who transition to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent test obtained while in the HMO”. Therefore, the patient is not required to undergo a repeat blood gas study, nor should the electronic break in service process be initiated (See LCD for Oxygen and Oxygen Equipment (L4967), page 4, Certification). However, the patient’s previous blood gas study must meet all other policy requirements upon return to Fee-For-Service Medicare. (See LCD for Oxygen and Oxygen Equipment (L4967), page 4, Certification)

14. A Medicaid patient has an authorization for oxygen and has been receiving oxygen services for 2 years. In January 2006, patient informs provider that she now has Medicare Part B benefits retroactive to August of 2005. Provider does not have a qualifying test until January 2006 when it was discovered that Medicare benefits became available retroactively. Before we file claims for the August-January period (which must be assigned because patient is dual eligible) can we have an ABN signed stating “Patient does not have qualifying test information due to retroactive eligibility?”

Yes, an Advanced Beneficiary Notice can be used in this case, due to no record of Medicare entitlement until after the services were rendered and billed to another carrier/program under their guidelines.

15. The medical policy states, should a patient qualify for Oxygen during exercise, there must be documentation in the medical record for the three tests, i.e. at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied. Does the patient have to have all these tests prior to set up and follow the initial criteria of qualifying 30 days prior? Or can the patient have the remaining tests after set up? Many Physicians have stated they do not have oxygen at their office to do the testing on oxygen since the patient has yet to be set up.



The Medical Policy states, When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the patients medical record i.e., testing at rest without oxygen, testing during exercise without oxygen and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the CMN. The other results do not have to be routinely submitted but must be available to the DMERC on request.

In order for the medical records to properly demonstrate the improvement of the hypoxemia, the patient must have all three tests prior to set up and follow the initial criteria of qualifying 30 days prior. This would ensure whether the patient meets the coverage criteria for oxygen during exercise. (See LCD for Oxygen and Oxygen Equipment, page 4, Certification Requirements.

Please note: Exercise testing is a real lab test and must be performed by entities qualified to administer the test using appropriate equipment under controlled conditions. Informal testing done in a physician's office does not qualify as a legitimate test.

16. It is stated if the qualifying test is obtained after the start date of Oxygen, the initial date of the CMN should be the date of the qualifying test (Refer FAQ 8-21-03 Q#11 and medical policy CH17) Is it necessary to have the physician make changes to the initial date of the CMN to reflect the test date, knowing that payment is based on the date of the qualifying test?

The "Initial Date" found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order. If there is a change made to any section of the CMN after the physician has completed Section B and signed Section D of the CMN, the physician must line through the correction, initial and date the correction; or the supplier may choose to have the physician complete a new CMN. Please refer to Region B DMERC Supplier Bulletin, September 2003 page 3 "Certificate of Medical Necessity – Common Scenarios" and the Region B DMERC Supplier Manual, Chapter 18, Certificate of Medical Necessity.

17. All major IDTF's that are promoting home oximetry for the purposes of qualifying Medicare patients for O2 therapy are indicating that this type of service can be used for to qualify a patient at rest, with exercise, and/or via an overnight study. Assuming that all of these IDTF's are in full compliance with Medicare Policy regarding this practice (physician ordered test, Medicare approved IDTF, instructions provided by IDTF, sealed/tamper-proof unit) can test results from these Medicare approved testing facilities be used to qualify a patient if the test was performed at rest (spot check)? Can they be used if the test was performed while exercising? Can they be used if the test was part of a 3-Step test (resting, exercise, on O2)? Are they only valid if done as an overnight oximetry study? Please advise as to when and how physician ordered test results from



Medicare approved IDTF's can be used to qualify a patient for stationary and portable oxygen as the existing policy is not clear on this issue.

The section on Testing Specifications within the LCD for Oxygen and Oxygen Equipment states the following:

“The qualifying blood gas study must be one that complies with the Fiscal Intermediary or Local Carrier policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test - i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purpose of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests.

For sleep oximetry studies, the oximeter provided to the patient must be tamper-proof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value”.

Medicare approved Independent Diagnostic Testing Facilities (IDTF) can be utilized to perform qualifying blood gas studies for patients requiring home oxygen therapy. Blood gas studies performed while the patient is at rest, during exercise, and/or while on O2 can be conducted by a Medicare approved IDTF. If the patient requires a sleep oximetry study, the policy states that that the oximeter provided must be tamper proof and must have the capability of downloading documentation of the duration of oxygen desaturation below a specific value. The Medicare guidelines do not impose any restrictions on blood gas studies conducted by the IDTF. Once the studies have been completed, the physician must complete the Certificate of Medical Necessity (CMN) for home oxygen therapy based off the results. Page 10 of the September 2005 bulletin addresses the Overnight Oximetry Testing policy.

18. We billed Medicare for a CPAP mask headgear release clip as A9999RPGA (verified code with the SADMERC) and Medicare changed the HCPC to A9900GACC and denied as CO-B15 (payment adjusted because this procedure/service is not paid separately). We sent a review to Medicare stating that the patient owns the mask and that replacement of the release clip is more cost effective than replacing the mask. We also sent pictures of the part and indicated in the review that the code was set by the SADMERC. The review was denied stating that the headgear clip is not covered because it is included in the allowance for the CPAP mask. Why pay for a new mask A7034 (allowable \$117.64) when we only billed \$11 for the replacement of the clip? The patient's mask is 7 months old and does not need to be replaced. Please explain why



Medicare would rather we bill for an item that will cost the program and the beneficiary more money?

This situation is being researched. Region B DMERC will provide suppliers with an update when available.

19. Regarding CPAP clients: CPAP patient had a sleep study in the 90's and was on Medicare at the time. According to the Medicare guidelines for coverage at that time, the patient did meet the Medicare guidelines so payment was made for the equipment and supplies. Client is returning for supplies, their unit might need repair or the patient has moved into our area and requires replacement supplies. The patient's sleep study does not have the information required to meet today's Medicare guidelines for CPAP. We would not be able to bill using the KX modifier. The main area that is missing from the older sleep study reports is the Pre-treatment time. Often when the person has severe OSA, their Pre-treatment time falls short of the 2 hours required. My questions are: **(1)** Do these patients need to have a repeat sleep study to determine if they still have OSA and meet today's Medicare requirements? **(2)** Will Medicare pay for a second sleep study? **(3)** Is there any Grandfathering in for those patients described above?
- 1. If the patient owns a CPAP which has previously been covered by Medicare, separate allowance can be made for the accessories, supplies, or repair, as long as the repair does not exceed the purchase price of a new CPAP. Medicare would still require the supplier to have an order from the physician and the specific diagnosis for the CPAP. A repeat sleep study would not be required for this scenario.**
 - 2. If the patient requires a new CPAP and the sleep study from 1990 does not meet the coverage criteria for current guidelines, a new sleep study would be required (See IOM-Pub. 100-02, Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, §110.2(A) - Repairs, Maintenance, Replacement, and Delivery). Please contact the local carrier with regards to the coverage criteria for the sleep study.**
 - 3. Grandfathering for patients who met the previous coverage criteria would occur with the implementation of the new policy. However, if there was a break in medical need or the patient required a new device, the patient must now meet the current criteria (See LCD for Continuous Positive Airway Pressure Systems (CPAP) (L11508).**

Prosthetics/Orthotics

20. Will Medicare approve and pay for a new lower limb prosthesis for a beneficiary with a lower limb amputation, who has recently taken delivery of a power wheelchair or scooter that was approved and paid for by Medicare?

These are likely contradictory pieces of equipment given the level of ambulation expected to qualify for most lower limb prosthesis. When billing for lower limb prosthesis and the patient has recently taken delivery of a power wheelchair or



scooter, it is imperative to secure the extensive documentation to support the need for the prosthesis, its components, and the patient's functional classification. (See LCD for Lower Limb Prostheses (L4957) for documentation requirements).

Rehab Equipment

21. We have received a call from a patient's family member that they are checking into a wheelchair for an older parent. They want us to come out to the home to see what might be needed (bath equipment, etc). We check for accessibility, etc. at that time. Is it a problem if we go to the home and do the home assessment BEFORE the physician orders a wheelchair? We cannot find anywhere where it says that the home assessment must be done AFTER the doctor has ordered the wheelchair.

The home assessment for Mobility Assistive Equipment (MAE) may be conducted prior to the order, when the request for the home assessment is initiated by the beneficiary or an authorized representative. Suppliers must maintain documentation of the request for the home assessment being initiated by the beneficiary or authorized representative, if the assessment is conducted prior to the order. Please reference the IOM-Pub 100-3 Medicare National Coverage Determination Chapter 1, §280.3(B) Mobility Assistive Equipment, for additional information.

22. For the home assessment, must we record measurements of doorways, rooms, etc., along with recording accessibility or is a simple attestation statement that the patient's home is accessible sufficient? Also, does the physician/clinician need a copy of that assessment/statement?

Mobility Assistive Equipment documentation requirements do not require the home assessment to include a recorded measurements of doorways, rooms, etc. Suppliers should document the facts of their assessment so that, in the event of an audit, reviewers can independently assess whether the provided equipment is appropriate.

23. The doctor's orders are to be dated within 30 days of the face to face. The orders are also to list all of the items to be dispensed. When the doctor does not order an independent/outside evaluation by PT/OT (that potentially extends the 30 day time frame), can we prepare the detailed order and ask the doctor to sign off on it for all components since he missed listing some of them? And does that order also have to be signed and received back by us within 30 days?

When the doctors order does not include all of the components required for the MAE being prescribed, it is an accepted practice for the supplier to contact the physician with a detailed order to sign off on. The supplier must be mindful of the medical documentation required to support the need for wheelchair accessories (i.e. reclining back, elevating leg rest, adjustable height armrest, etc.). Therefore, it is imperative that the supplier and the physician work together to ensure that all pertinent medical documentation from the patients' medical record is provided to



support the detailed order being prepared. Please refer to the Physician Documentation Letter located on the AdminaStar Federal Web site at the following web address:

<http://www.adminastar.com/News/DMERCNews/files/DocumentationMDletter.pdf>

24. Since the IFR has been postponed until April 1, 2006, seemingly postponing the availability of this reimbursement for the physician under the G code, will the G code still be valid for dates of service 1/1/2006 through 3/31/2006 for PMDs ordered during that time frame?

Yes, Local Carriers have received CMS instruction on the processing of HCPCS code G0372. For more information, please reference CR 4372 at <http://new.cms.hhs.gov/transmittals/downloads/R215OTN.pdf>.

25. When we obtain the detailed order for the accessories on a wheelchair will DMERC require the narrative of why the accessories are needed to be on the order?

Yes, when billing for wheelchair accessories the documentation secured from the physician or the OT/PT must clearly state why the accessories are needed. The medical necessity for the accessories may be documented in the form of a detailed order including a narrative description explaining why the accessories are required, or in the evaluation conducted by the physician or the OT/PT. The coverage criteria for wheelchair accessories have not changed. Please refer to the IOM-Pub 100-3 Medicare National Coverage Determination Chapter 1, §280.3 Mobility Assistive Equipment, LCD for Motorized/Power Wheelchair Bases (L4959), and the LCD for Manual Wheelchair Bases (L4958) for additional documentation requirements.

26. A patient has a wheelchair purchased through another funding source (not Medicare). However, Medicare is NOW primary, and has since established medical necessity for the chair and paid for repair. Now the chair needs replaced. Even though Medicare did not pay for the purchase of the wheelchair, does Medicare require a cost analysis for the repairs on the current chair vs. purchasing a new chair?

In the scenario indicated above, Medicare has established medical necessity for the patient owned chair and has also allowed payment for the repair. The claim for the new wheelchair should include documentation of why the previous chair could not be repaired. In addition, the supplier must secure the appropriate documentation as stated in the LCD for Motorized/Power Wheelchair Bases (L4959), and/or LCD for Manual Wheelchair Bases (L4958) and Pub. 100-02, Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, §110.2(A) - Repairs, Maintenance, Replacement, and Delivery.

27. When we supply a K0005 wheelchair to a patient, is a letter from the doctor still needed for activity levels or is it now acceptable to get this information on the clinical evaluation and would that be sufficient?



The LCD for Manual Wheelchair Bases (L4958) states:

“If the DMERC requests documentation of the medical necessity for a K0005 wheelchair, the documentation must include a description of the patient's routine activities. This may include what types of activities the patient frequently encounters and whether the patient is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base.”

A letter from the ordering physician will not be required if the clinical evaluation contains detailed activity level information to substantiate the medical necessity requirements. The evaluation alone may be sufficient.

Ostomy/Urological/Medical Supplies

There are no questions

Diabetic Monitoring and Supplies

There are no questions

Documentation/Regulatory/Miscellaneous

28. Do we submit electronically to Break-in-Service to extend the CMN, if more than just the diagnosis has changed such as the height or weight, which would substantiate a new capped rental?

A Break in Service is defined as a substantial change in the patient’s medical condition which would warrant significantly different equipment. If the length of need on the Certificate of Medical Necessity (CMN) needs to be extended, please provide detailed information explaining why and for how long the CMN needs to be extended in the note segment field of the electronic claim.

If a patient’s current piece of equipment no longer meets their medical need due to the significant changes in the patient’s height and/or weight, a new piece of equipment would be warranted. The Region B DMERC does not consider this situation as a valid Break in Service however; if the new piece of equipment is considered an upgraded item, a new capped rental period will begin. Documentation supporting the change in the patient’s medical need must be kept on file by the supplier and available to the DMERC upon request.

The following examples will assist suppliers when evaluating whether or not a valid Break in Service has occurred:

Example #1 – A patient falls and fractures their hip and receives a K0001 wheelchair. Two months later, the same patient suffers a stroke. The patient can no



longer propel the standard the standard weight wheelchair and now needs a lightweight wheelchair, K0004. There is no requirement for the interruption of 60+ days in this situation.

Example #2 – A patient breaks their hip and recovers. The wheelchair the patient was using is returned. Patient fell and broke their other hip and needs another wheelchair. The interruption must be 60+ days or more in this situation.

(Please refer to the break in service flow chart located on our website at <http://www.adminastar.com/Providers/DMERC/MedicareManuals/files/BreakInServiceBillingChart.pdf>)

29. Would you please revisit the question of how we can submit an electronic claim and get it through the front-end editor when a patient purchases a Medicare billable item but has no prescription for the item? Specifically, what do we enter in the physician info, UPIN #, and patient diagnosis fields that will allow it to pass through the front-end editor without being rejected?

When billing for a service provided without a physician’s order use “No Physician” for the ordering physician’s name, the surrogate UPIN OTH000 and ICD-9 code 799.9 (Other unknown and unspecified cause). Please refer to the Region B DMERC June 2003 Supplier Bulletin page 8, article titled “EY Modifier Use – Clarification” for additional instructions.

NOTE: As of April 1, 2006, OTH 000 will not be valid. New instructions will be published in a list serve message and bulletin article as soon as they become available.

30. Chapter 4 of the Region B DMERC Supplier Manual (pages 1-3) provides three examples of how much Medicare will pay when Medicare is the Secondary Payer on assigned claims. However there is no example regarding Unassigned Claims.

Since Medicare’s role as a secondary payer “is similar to the coordination of benefits clauses in private health insurance policies” (Chapter 4, Supplier Manual), would the calculations below be correct under the following scenario for an Unassigned Claim?

SAMPLE CASE SCENARIO:

The patient receives an above knee endoskeletal prosthesis (L5321) from a provider, who does not participate or accept assignment from either the primary insurer or Medicare. The patient understands that he may be responsible for any outstanding balance. This case assumes the Medicare deductible has been met for this beneficiary.

Provider’s Charge	\$4,165.00
Primary Insurer’s Allowance	\$3,123.00
Primary Insurer’s Payment	\$2,792.00



Patient Balance reported \$1,373.00
On E.O.B statement from Primary Payer

Medicare Allowance for procedure L5321 \$2,881.74

Medicare Liability without regard to Other Insurance. $\$2,881.74 \times 80\% = \$2,305.39$

Medicare Liability Considering Other Insurer's Payment $\$4,165.00 - \$2,792.00 = \$1,373.00$

Is this correct? Would Medicare pay \$1,373.00 to the beneficiary, leaving a zero balance to the patient?

If this not correct, what would Medicare pay to the beneficiary? Would the patient be responsible for the balance?

The calculation for Medicare Secondary Payment is the same regardless of assignment. The calculation for this scenario provided is correct. Medicare would pay the beneficiary \$1373.00 for this service.

31. Recently we have noticed an increase in claims that are not crossing over to Minnesota Medicaid. When I called Region B DMERC customer service they could not tell me why these claims did not cross over. I was instructed to call the COB carrier, which I did, the person I spoke to there told me they do not have claim information and that I should call Region B DMERC customer service. The beneficiaries have been in the system for years and nothing has changed with their Medicaid coverage. I called Medicaid to verify coverage and the fact that the eligibility tape was sent on a timely basis. I was told the people were not only eligible but that the tape was sent on time. Has there been a system problem that we are not aware of? Is there an educational issue within Medicare regarding cross over claims?

Minnesota Medicaid submits a monthly eligibility file to AdminaStar Federal which lists a coverage end date of the last day of the month. (i.e., December file shows all eligible from 12/1 through 12/31). These files are not always received on the first day of the month. If a Medicare claim is submitted at the beginning of the month and the current eligibility file is not received, the claim will not crossover to Minnesota Medicaid (These claims would process against the November file which shows an eligibility end date of November 30).

32. Canes and Walkers: We have been advised that we need to be obtaining a home evaluation for both pieces of equipment. Can you please advise how providers should be handling documentation on these equipment types? What does Region B consider a "home evaluation" for this purpose? Is the HME provider required to make a home delivery and assessment or can this assessment be accomplished verbally by interviewing the patient/caregiver without being physically in the home?



The coverage criterion for Canes and Walkers does not require the supplier to conduct a home assessment. The physician must provide an order, fit the patient with a cane or walker and assess the patient's ability to safely use a cane or walker (See LCD for Canes and Crutches (L11474) and IOM-Pub 100-3 Medicare National Coverage Determination Chapter 1, §280.3 Mobility Assistive Equipment).

33. Does the physician have to hand-write the date on a prescription? We have a clinic that types up their 3x5 prescriptions with all of the information we need to use it as a detailed written order for many DME items. The date is typed at the top and the physician signs it, but does not date it. Would this prescription be valid to use as a detailed written order?

No, the order would not be considered valid. The detailed written order must contain the beneficiary's name, the signature of the treating physician, and the date that the order is signed. The detailed description of the item may be completed by someone other than the physician. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. Please refer to the Region B DMERC Supplier Manual, Chapter 17, Medical Policy, General Information, Page 7 and the IOM Pub. 100-08, Program Integrity Manual, Chapter 5, §5.1.1.2 for detailed instructions on orders.

34. For break-in-service claims sent electronically, what are the instructions for extending the CMN? This was not addressed in the list serve notice other than to send a new CMN if necessary.

If a Break in Billing of 60 days or more has occurred, electronic claim submitters should be aware that the CMN end date will be extended if 15 rental payments have not previously been made.

35. If a patient in Hospice has a diagnosis that is not related to their Hospice enrollment, will DMERC pay for DME equipment for the non Hospice diagnosis?

Yes, the DMERC will pay for DME provided due to a non-related hospice diagnosis. Direction for this process has been provided in the IOM-Medicare Claims Processing Manual, 100-4, Chapter 11, §50-Billing and Payment for Services Unrelated to Terminal Illness. This section states the following:

“Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the FI or carrier for non-hospice Medicare payment. These services are coded with the GW modifier “service not related to the hospice patient's terminal condition”.

Please note: This is not a diagnosis driven determination. In terminal patients there may be several disease conditions that are contributing to the terminal condition. Hospice may choose to report only one. In an audit, review of the service would be



more comprehensive. Suppliers should be aware that simply having a different diagnosis from the hospice admission diagnosis does not guarantee that the item or service provided falls within DMERC jurisdiction.

36. When we send for an ADMC and it is approved, is this for medical necessity only or does the ADMC department also check equipment history?

Once a request is received, the DMERC or DMERC PSC shall determine if there is sufficient medical documentation that supports whether the item is reasonable and necessary. In addition, a review of the beneficiary's claims' history should be conducted in order to determine whether any other reason exists to cause the claim to be denied, e.g., whether the same or similar equipment has already been provided. IOM- Medicare Claims Processing Manual, 100-8, Chapter 5, §5.7.4 – Instructions for Processing ADMC Requests.

37. Is there an easy way through your website to find the correct modifiers for billing (a quick reference guide) such as the KX modifier? We have had many codes added to our billing that require the KX and a list of the items that require this code would reduce the amount of denials.

Each Local Coverage Determination (LCD) found in the Region B DMERC Supplier Manual Chapter 17 entitled "Medical Policy" has a Coding information section. The coding information section includes a listing of both HCPCS codes for the policy as well as the HCPCS modifiers for claim submission. Chapter 16 of the Region B DMERC Supplier Manual entitled "HCPCS codes" provides a complete listing of modifiers and their descriptions beginning on page 103.

Other

38. When we suspect fraud or abuse as a supplier (Medicare paid a supplier for a power wheelchair that is sitting in the patient's garage and won't even fit in the house, and the patient needs a new manual wheelchair because they are still using their old manual wheelchair in the home and it is worn out, for example), who should we be calling?. Should we call DMERC Customer Service, Benefits Integrity, or the OIG?

**The TriCenturion home page has a link to report Medicare fraud. Please paste the following into your internet browser.
http://www.tricenturion.com/content/report_fraud.cfm**

Please complete the Referral to Benefit Integrity form to report suspected Medicare fraud.

You may also report suspected fraud or abuse by calling the Inspector General's hotline at the following: 1-800-HHS-TIPS (1-800-447-8477)



Medicare Region B DMERC

39. For Voluntary Refunds it states we can use the Offset Form. The Off set form states for claim adjustments the provider submit a copy of the Voluntary Refund Form. Once the claim is adjusted and accounts receivable created, the debt would be immediately set up for offset and a demand letter will still generate. However, Chapter 14 in medical policy under Voluntary Refunds states to have the refund check. Can we use the Offset Form to initiate a voluntary refund by asking Medicare to do an offset? Or is this form only to be used when the Provider has the refund check up front to submit?

Chapter 14 of the Region B DMERC Supplier Manual provides instructions for both the voluntary refund and immediate offset request processes. If the supplier chooses to voluntarily refund Medicare suppliers are instructed to complete and mail the Voluntary Refund Form. If the supplier chooses to notify Medicare of a voluntary overpayment and elects to have the overpayment settled via immediate offset, the supplier must complete and fax both the Voluntary Refund Form and Offset Request form. If a voluntary refund form is received via fax, the Payment Correction Unit will automatically set up the receivable for immediate offset.