Jurisdiction B, C, D Combined Council Questions

Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **(C) The Medicare Administrative Contractor (MAC) requirement to match DME Information Form (DIF) initial dates causes suppliers unnecessary denials. Assume that ABC Medical provides enteral supplies to a client, and subsequently bills for reimbursement. However, ABC Medical receives a denial to its claim, and the DIF (which was submitted to support that claim) is put into a nonpayable status.**

   Enter change of supplier, (most likely caused by competitive bidding). The new supplier XYZ Supply sets up the client. As a part of the intake process, XYZ Supply contacts the telephone interactive voice response (IVR) to check on same/similar, number of months paid on a capped rental, and initial date for the DIF. The IVR responds there is no DIF on file (because it's in a nonpayable status). XYZ Supplier, having what it believes to be current information, creates a new Initial DIF and submits its first month claim and is paid.

   The previous supplier has been going down the appeals path, and several months later, ABC Medical has successfully proven the medical necessity of its claims and the claims are required to be paid. To do this, the DME MAC makes ABC Medical's previously nonpayable DIF payable. Along with that action, the DME MAC has changed the client's initial date for this service.

   XYZ Supplier submits its next claim for payment. XYZ Supplier, after having been paid on the past several months' worth of claims, is suddenly denied for invalid initial date. Or, when XYZ Supplier files a revised DIF the revised DIF is denied because XYZ Supply was not made aware that the initial date was reset by the DME MAC.

   Why do initial dates continue to be required to match in order to allow payment? Will the DME MAC consider removing the requirement to have initial dates match (perhaps similar to logic in place for the oxygen policy which is therapy-based) because such requirement does not add value to the validity of the payable/nonpayable status of the claim? As an alternative, can the DME MAC notify the current supplier that a change to the initial date has been forced by the DME MAC due to a payment correction to the former supplier?

   Response: Initial dates are used to review for break-in-service and medical necessity situations. This is normal processing and the current supplier should submit the appropriate Certificate of Medical Necessity (CMN) for processing the date of service billed.

2. **(C) The DME MAC processing logic occasionally inputs a fake revised DIF to hold future claim payments. When it doesn't remove the DIF at a later date, denials occur.**

When an additional documentation request (ADR) is generated for enteral supplies, a "placeholder" revised DIF is created by the DME MAC processing team. The revision date on the DIF matches the date of service that the ADR is intending to review. This supplier suspects the revised "place holder" DIF is created to suspend future claims from paying until the current ADR is settled (reviewed) by the DME MAC.

When the ADR involved claim is eventually approved for payment, on several occasions suppliers have observed that the "placeholder" revised DIF is not removed from the DME MAC claims processing system. While the "placeholder" revised DIF remains active, the last supplier revised DIF and the DME MAC placeholder revised DIF conflict and cause the claim to process incorrectly and/or pay at the incorrect rate during that window of time. Correcting this situation normally requires a half hour of DME MAC customer service representative (CSR) and supplier biller time on the phone. Alternatively the supplier must utilize the appeals/review process which again, consumes valuable resources unnecessarily. The issue appears to be growing in scope. We've observed this over the past two years, but the frequency is greater recently.

Can the DME MAC utilize a different method for holding future payments on a beneficiary other than the creation of the "placeholder" revised DIF? Can an article be published on how to resolve the issue so that suppliers can direct DME MAC CSRs to the article? If the placeholder DIF is not removed in a reasonable amount of time, to who should the supplier directs the request to quickly resolve/escalate for resolution?

Response: When processing errors occur, suppliers should contact Customer Service for further instructions. If the claims were processed erroneously (i.e. DIF was not updated appropriately) they may be corrected by the contractor. In some cases the correction occurs without further action from the supplier and in others it may require the supplier to contact reopenings or request an appeal.

3. **(D) We would like to ask for further clarification on our question based on the instruction below, copied from the parenteral nutrition (PN) policy article – Effective May 2013 (A37077) under MISCELLANEOUS:**

   Parenteral nutrition can be covered in a beneficiary with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral (or even oral/enteral/parenteral) intake as long as the following criteria are met: 1a) a permanent condition of the alimentary tract is present which has been deemed to require parenteral therapy because of its severity (criteria A-F); or 1b) a permanent condition of the alimentary tract is present which is unresponsive to standard medical management (criterion H); and 2) the person is unable to maintain weight and strength (criterion G).

   If the coverage requirements for parenteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

   In situations where the treatment plan may involve a beneficiary receiving enteral nutrition (EN) to determine tolerance, then transitioned to total parenteral nutrition (TPN) therapy for a period of time, and back to enteral with no break in service/need, can the length of need be combined for TPN/EN and considered as continuous to meet the 90 day duration requirement? Or would the beneficiary have to be on enteral for 90 days, then TPN for 90 days in order to meet the test of permanence?

   A follow-up question: If a beneficiary is started on TPN, then slowly transitioned to enteral therapy with no break in service, would this be considered "continuous" to meet the 90-day duration requirement, or would patient have to be on TPN for 90 days (prior to transition to enteral) to be considered as meeting the test of permanence?

   Response: Parenteral and enteral nutrition therapies are governed by two different coverage policies. In addition, the test of permanence is not predicated on how long someone has been on parenteral or enteral therapy but rather the disease condition necessitating the parenteral or enteral nutrition and the treating physician's determination that the disease condition is of "long and indefinite duration." CMS has interpreted the "long and indefinite duration" to be a minimum of 90 days.

4. (D) We have recently started to see denials in Jurisdiction D and Jurisdiction B for not indicating both the method of administration (MOA) and the route of administration (ROA) on the detailed written order (DWO) for enteral. Providers list the MOA as being pump, gravity, or bolus on the DWO which correlates with Q. 5 for MOA on the DIF. The patient's medical record supports the enteral is administered via feeding tube and is also acknowledged by question 2 on the DIF. The local coverage determination (LCD) states we would append the modifier BO if enteral is for oral administration, as then it would be considered noncovered.

We have observed conflicting information from recent enteral Webinars by Jurisdictions C, D, and A, as well as in comparison to the *Medicare Program Integrity Manual (PIM)*. Please see all references below:

Jurisdiction C recent Webinar states:

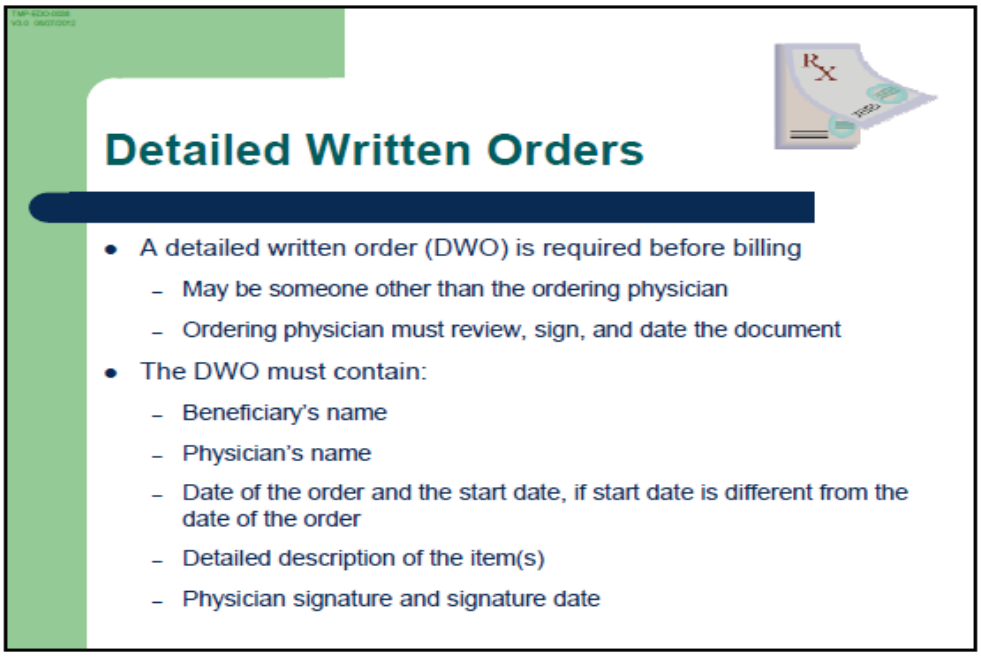
The detailed written order should contain:

- **Beneficiary's name**
- **Description or name of the nutrient to be administered**
- **Administration instructions: method (syringe, gravity or pump), rate and/or frequency, amount**
- **Number of refills**
- **The treating physician's signature**
- **The date the treating physician signed the order**
- **The start date of the order, if different than the signature date**
- **If the order is for a rented item or if the coverage criteria in a policy specify a length of need, the order must include the length of need**

Jurisdiction D recent Webinar states:

- **Additional detailed order elements:**
- **Accessories or supplies**
- **Quantity used**
- **Frequency of change or use**
- **Formula**
- **Calories per day**
- **Method and route of administration, duration of infusion (This appears to be new instruction for both MOA and ROA)**

Jurisdiction A Enteral Webinar 7.2012 Instruction:



PIM: DETAILED WRITTEN ORDERS (PIM 5.2.3)

For items provided on a periodic basis, including drugs, the written order must include:

- **Item(s) to be dispensed**
- **Dosage or concentration, if applicable**
- **Route of Administration (Note: PIM does not require both MOA and ROA)**
- **Frequency of use**
- **Duration of infusion, if applicable**
- **Quantity to be dispensed**
- **Number of refills**

Below is an example of how we as suppliers have interpreted the PIM to prepare a complete detailed written order (DWO). Note that the PIM DOES NOT require both MOA and ROA, so we have completed the DWO as noted below in red.

- **Item to be dispensed (would be formula, pump, and supply kits – supplier would include the feeding tube type on the DWO in situation of replacement and we bill for it)**
- **Dosage or concentration, when applicable (would be the number of calories or cans/day or cc per hour over #/hours.)**
- **Route of administration (would be gravity, pump, or bolus syringe – we have the verbal order for feeding tube type and it is answered on the DIF as via tube)**
- **Frequency of use (generally daily)**
- **Duration of infusion, when applicable (again would be cc/hour over **/hours…or # cans/ bolus X **/day etc. etc.)**
- **Quantity to be dispensed (is noted above with the dose and concentration, etc.)**
- **Number of refills (duration of therapy ordered, i.e. 90 days six months, lifetime, etc.)**
- **Physician signature and signature date**

Can the various DME MACs provide consistent instruction on these requirements in order to match what is written in the PIM?

Response: The PIM requires route of administration and for Medicare's purposes, route of administration or method of administration are considered to be the same. A DWO needs to be specific and everything separately billed must be listed. In the specific example of enteral nutrition, the DME MACs look for the appropriate supply kit billed (i.e., gravity, pump or syringe) and the appropriate tube (i.e., nasogastric tubes or gastrostomy/jejunostomy tube).

5. **(D) Can noncontracted providers in the Round 1 Recompete (R1RC) Competitive Bidding Areas (CBAs) bill Medicare for denial for the external infusion pump and supplies and receive a PR denial when services (drugs) are not covered by the LCD, thus allowing the provider to bill the patient or secondary insurance?**

   Note: The Competitive Bidding Implementation Contractor (CBIC) has answered yes to this question and has offered to run test claims to confirm. As of 11/5/13 we have not received the test claim results and would like to confirm with the DME MACs that a PR denial will be obtained by noncontracted providers when billing for denial when services (drugs) are not covered by the External Infusion Pump (EIP) LCD, or the patient does not meet the medical necessity criteria in the EIP LCD.

   Response: Yes, if the claim is covered by an appropriate advance beneficiary notice of noncoverage (ABN).

6. **(D) Can a noncontracted supplier (pharmacy) that chooses to grandfather the external infusion pump (EIP):**

   a. **Provide all items necessary to infuse drugs in the home environment (pump, supplies and drug) until the pump caps?**

      Response: Yes, however, once the pump caps, the beneficiary must receive his/her supplies from a contract supplier.

   b. **Once the pump caps, can the noncontracted provider continue to bill for the drug and pump repairs as needed (as these services are not subject to contracting)?**

      Response: Yes

   c. **Will the administration bag/cassette that contains the covered drug be payable to the noncontracted provider after the pump caps (especially since the grandfathered supplier is the one that provided the pump and continues to provide the drug, and many of the contracted providers cannot even dispense the drug as they do not have the proper pharmacy credentials)?**

      Response: No, the cassettes must be obtained from a contract supplier

      i. If the beneficiary chooses to stay with the grandfathered provider after the cap and the supplies are not separately payable, can the noncontracted provider continue to provide the administration bag/cassette that contains the covered drug (after the cap)?

         Response: See answer to 6.b

      ii. If the beneficiary signs an ABN to accept financial responsibility, will the claim submitted with a GA modifier deny with patient responsibility?

         Response: Yes

iii. As an alternative, can the beneficiary choose to waive their right to file a claim to Medicare via an ABN (selecting Option 2)?

Response: Yes

7. **(D) A supplier is furnishing TPN therapy to a beneficiary. The supplier is billing for items that are included in a daily "kit" code, e.g.: TPN administration supply kits.**

Required supplies will vary for each patient depending on what type of IV access device the patient has (i.e. PICC, Hickman, Broviac, etc.) and the method of administration (pump sets, bags, cassettes, etc.). These items are considered to be part of the "kit" healthcare common procedure coding system (HCPCS) code and are reimbursed as a kit for each day of administration.

There has been concern in the industry that auditors are looking for documentation of an inventory of each individual supply item with resulting denials for not meeting the request for refill (RFR) requirement for supplies, when in fact there is documentation of suppliers contacting beneficiaries to determine the remaining amount of base product on hand, and when the next delivery will be needed.

For example, enteral therapy supply kits B4034–B4036 are not subject to the Request for Refill requirements since they are an all-inclusive kit required for each day of administration.

Therefore, is it correct to state that for TPN therapy Parenteral Nutrition Administration Kit, Per Day, B4224 and Parenteral Nutrition Supply Kit; Premix, Per Day B4220 codes should not be subject to the RFR requirements?

Response: No, the supplier does not have to document the remaining individual supplies. Enteral supplies are based on a daily allowance to supply all necessary supplies to maintain the enteral administration. Suppliers need to confirm the remaining quantities of supplies on-hand are sufficient to allow administration of the enteral nutrients.

Home Medical Equipment

8. **(B) With low air loss's (LAL), E0277, the LCD states:**

"Continued use of a group 2 support surface is covered until the ulcer is healed, or if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 is reasonable and necessary for wound management."

The next paragraph reads:

"The provider should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the KX modifier still reflects the clinical conditions which meet the criteria for coverage of a group 2 support surface, and that adequate documentation exists in the medical record reflecting these conditions."

We have had at least two cases in the past several months where the family did away with the on-going clinical visits, either to the MD or with Home Health AFTER the need for the LAL was established. When we go to the home, there is still a very clear need for the LAL but the family's refusal to see someone clinical on at least a monthly basis does not allow us to obtain the required documentation to meet guidelines for the KX modifier. In some cases, the family may provide us with their daily routine of caring for the beneficiary and the wound may or may not be healing. Is there any documentation that Medicare will consider in lieu of clinical documentation to support the continued need of the LAL and pay for the monthly rental when both the family and the provider can certify the wound has not yet completely healed?

Response: No

9. **(B) When a patient is first set up with a negative pressure wound therapy pump (NPWT) pump (E2402), providers spend time with verbal education and leave an "Instructions for Use Manual" with each patient. Patients then sign an acknowledgement of receiving the handbook. Is this protocol acceptable for orientation to product use?**

   Response: The CMS Quality Standards require patient and family education. Section II(C) states: Ensure that the beneficiary and/or caregiver(s) can use all equipment and item(s) provided safely and effectively in the settings of anticipated use.

10. **(B) There is currently a draft policy for pneumatic arterial pumps. Since it is only a draft, are the pneumatic arterial pumps covered currently? If they are covered, what guidance can you give us as far as qualifying a beneficiary for coverage?**

    Response: There is no draft policy for pneumatic arterial pumps. Pneumatic arterial compression is addressed in the draft pneumatic compression devices LCD. Until the draft pneumatic compression devices LCD is finalized, pneumatic compression is only covered for the indications listed in the current LCD.

Oxygen

11. **(B) A patient has a qualifying sleep study to diagnose obstructive sleep apnea (OSA). During the qualifying sleep study the patient has an oxygen desaturation below 88%. The patient is NOT started on a continuous positive airway pressure (CPAP) device, but is scheduled for a titration sleep study. During the titration sleep study, adjustments are made to pressures and the interfaces changed in order to get best fit; the results of the titration sleep study show that after these changes the patient is still desaturating to 88% or less. Following the titration sleep study, the sleep specialty doctor orders CPAP with oxygen in line. Based on this scenario, is it correct to provide and bill for the CPAP and oxygen on the same date of service?**

    Response: The article titled "Frequently Asked Questions: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea" – published by all DME MACs, addresses this question.

12. **(C) In the discussion of Medicare oxygen coverage in our last Council meeting, an issue was raised regarding appropriate diagnoses for coverage of oxygen and the answer received was that the oxygen policy was not diagnosis-driven. In regard to this issue, please provide guidance on the following scenarios:**

    a. **In the case of a CPAP patient with OSA – if there is documentation that shows controlled apneas, but continued desaturations which meet the Medicare sleeping saturation test criteria, is it necessary for the physician to determine a chronic lung disease in addition to OSA? (While we see a number of patients who continue to desaturate, even when the apneas are controlled, it is not always common to see the physician document an additional disease.)**

       Response: If the study demonstrating the "controlled apneas" is a titration polysomnogram (PSG), then the physician would still to document that the beneficiary meets the oxygen LCD requirements.

    b. **If the diagnosis is of a condition that can affect the respiratory system (e.g. congestive heart failure [CHF], amyotrophic lateral sclerosis [ALS], etc.) appears in the medical chart, will oxygen be covered if the physician "connects the dots" in his documentation, even in the absence of the diagnosis of a severe lung disease?**

       Response: There are a number of coverage requirements in the oxygen LCD and the beneficiary must meet the requirements in order for oxygen to be covered.

13. **(C) We have a beneficiary who is eligible for replacement nocturnal O2 equipment and is also on positive airway pressure (PAP) therapy (concurrent use) but the prior titration study does not contain enough detail to determine if the patient desaturated for five or more minutes at their optimum pressure. If their doctor has documented the patient is compliant with their PAP therapy and is in a stable state, does the patient need to have another facility-based titration study or would an overnight oximetry performed by an independent diagnostic testing facility (IDTF) (which documents the beneficiary is using their PAP) be sufficient to qualify the patient for replacement oxygen equipment?**

    Response: Unable to respond because there is not enough information about under what circumstances the oxygen equipment is being replaced.

14. **(C) Regarding a recently issued frequently asked questions (FAQ) document published in Jurisdiction C on November 22, 2013, titled "Oxygen Use in Beneficiaries with Obstructive Sleep Apnea," Question 7 reads:**

    A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary was prescribed a PAP and the physician has ordered a home overnight oximetry test that was performed on room air with the beneficiary using their PAP device. The beneficiary desaturated below 88% for more than five total minutes. In this instance, would the home oxygen be covered?

    Response: No, home oxygen would not be covered. Only testing with a titration PSG may be used to qualify a beneficiary with OSA for concurrent payment of home oxygen.

    Can you please elaborate on why a facility-based titration study is required in this instance? And more specifically, why an overnight oximetry (deemed an acceptable diagnostic tool in the oxygen policy) paralleled with compliant PAP therapy (to be documented by the same technology deemed acceptable to demonstrate compliance in the PAP policy), would not be equally sufficient compared to a more costly (and more inconvenient) facility based titration study?

    Response: The chronic stable state requirements for oxygen must be met. Titration PSG showing that the OSA is resolved is the only testing methodology that provides the necessary information to make the chronic stable state assessment in an OSA beneficiary

PAP/Other Respiratory Care Equipment

15. **(B) Are home medical equipment (HME) providers required to offer a second chance to meet the PAP LCD requirements (especially the continued rental compliance/use %) or is this a business decision? If the patient does not meet the LCD policy requirements and you have given an ABN during the third month of the trial, can you bill the patient if they wish to continue to use PAP?**

    Response: Once the ABN has been successfully issued, there is no requirement to offer a second chance.

16. **(C) A PAP supply patient changes to a new provider to order PAP supplies. An item of qualifying documentation cannot be located to determine medical necessity, for example, the previous provider and the treating physician cannot provide compliance data from the initial 90 days of PAP therapy. Instead of signing an ABN for supplies, the patient decides to have a repeat face-to-face evaluation, a repeat facility-based PSG, and now would like to go through a repeat trial period in order to qualify for supplies. The patient already has a PAP device from the previous provider, which is why the patient originally called the new provider for replacement PAP supplies.**

    Is the new provider supposed to deliver a new PAP device to the patient in order for the patient to complete the repeat trial period or is the patient supposed to complete the repeat trial period on the equipment currently in the patient's possession? And if the new provider is supposed to deliver a new PAP device to the patient, how will the new provider get paid since the patient already has a same/similar

piece of equipment (the equipment may have been billed all 13 months rental or may have only been billed for the first three months but never picked up by the previous provider from the beneficiary).

Response: The new supplier is responsible for demonstrating that medical necessity for the equipment and supplies has been met. Repeating the qualification process is not an acceptable solution for documentation that is required to be obtained with the initial qualification period (i.e., first three months). Supplier #2 cannot bill for equipment provided by supplier #1 or equipment owned by the beneficiary. An ABN is appropriate in this situation.

17. **(D) We are seeing a large number of patients that are switching to different providers to get their PAP supplies due to their supplier either going out of business or they did not receive a contract under CBA. When these patients are switching companies, we are not always able to get the required documentation such as the compliance download showing the patient has met the coverage criteria and the previous supplier was able to bill after the three-month trial period.**

    Are we able to utilize an ABN for these patients after we have made a good faith effort to obtain the download stating we are unable to verify the patient has met the compliance of four hours per day, 70% of the time during the first three months of usage? Should the claim be communicated without the KX modifier for the accessories in instances where we cannot independently establish the historical compliance criteria?

    Response: An ABN is valid, specific to the beneficiary's situation. The claim should be billed without the KX modifier, and with the GA modifier.

18. **(D) Nebulizers: We are seeing claims for respiratory medications get denied for lacking information that the beneficiary has a nebulizer. The nebulizers are paid for through the Medicare Program. This information should already be in the Medicare system. In some cases, the nebulizers' useful life exceeds five years. We see this happening across all four MACs.**

    a. **Are the contractors' systems looking back further than five years to determine that a nebulizer was paid for?**

        Response: Yes

    b. **Could the claim be developed for additional information instead of denying the claim?**

        Response: This is a processing decision made at each DME MAC.

    c. **If the claim has a narrative attached stating the beneficiary has a nebulizer...would that prevent the denial?**

        Response: Yes a narrative indicating the type of compressor/HCPCS code, and that the item is beneficiary owned and when it was purchased (month, year).

    d. **If the systems cannot provide a "look back", or if the system cannot look to the narrative prior to denial, could a modifier be a reasonable solution?**

        Response: There is not a modifier used to indicate the equipment was previously purchased.

Prosthetics/Orthotics

19. **(D) The LCD for knee orthoses describes ligament and osteoarthritis (OA) bracing. Ligament bracing is consistent with injury or instability caused by tear or progressive injuries. Instability testing is pertinent to qualifying the need for ligament bracing. OA bracing, however, is prescribed to open the medial or lateral compartments and relieve pain thus assisting in ambulation and the activities of daily living.**

Requiring the types of instability testing associated with ligamentous conditions is inapplicable to the need for OA bracing. Therefore, why doesn't the LCD reference the instability testing specifically to ligament or postsurgical bracing instead of generally to all knee orthotics?

Osteoarthritis braces are commonly coded under L1843 or L1845 for off the shelf (OTS) products and L1844 and L1846 for custom. According to Medicare's policy article, these codes are for OA braces that are designed to open the medial or lateral compartment and relieve pain. This is consistent with the reasons for ordering by practicing physicians. The LCD, however, is inconsistent with this application. The LCD states that the patient must have a recent injury or surgery to the knee OR be ambulatory with instability.

Patients with osteoarthritis will manifest the statutory definition of a diseased body part requiring bracing; however, they generally do not have a specific injury. They have a history of pain that has gotten worse over time as the joint degradation occurs. It is unlikely to see a specific "injury" in the history. Additionally, they typically have not had recent surgery. Common surgical procedures for OA are arthroscopy (which is no longer covered for severe OA or OA with knee pain only) and arthroplasty, which usually negates the need for a brace. Neither of these qualifications fit the typical OA patient.

The third option is "a beneficiary who is ambulatory and has knee instability." Most OA patients are ambulatory, but most do not have instability in their knee in the "classic" sense as described in the test requirements: "knee instability must be documented by examination of the beneficiary and objective description of joint laxity." On occasion, when deformity is severe, there may be laxity of a collateral ligament that is measurable on objective stress tests. Occasionally, there is loss of joint space in one compartment that may cause laxity in the opposite collateral ligament. However, most patients present with pain, not laxity. The examples stated in the LCD are both tests for ligament laxity, which is consistent for a ligament brace (Knee ligamentous disruption, 717.81 – 717.9 or Meniscal cartilage derangement, 717.0 – 717.5) but inconsistent for an OA brace.

Additionally, laxity is not included in the American College of Rheumatology's criteria for OA diagnosis. Therefore, most physicians do not perform these tests in the diagnosis of osteoarthritis as they would be unnecessary. To require that a patient must have injury, surgery or instability in order to qualify for an OA brace is incompatible with the presentation of the disease and the evaluation procedures of medical professionals.

Can the LCD language be revised to reflect a more accurate coverage criteria for this group of beneficiaries, or is it Medicare's intent to exclude coverage for the diseased body part and limit payment to instances of specific injury, surgery or instability?

Response: Please use the LCD reconsideration process should one wish to propose a change to the LCD. Information on the LCD reconsideration process is available on the DME MAC Web sites.

Rehab Equipment

20. (C) For the sake of "least costly alternative," is it appropriate to add an aftermarket powered seating system (e.g. E1002–E1008) to a no power option wheelchair base or should a brand new base and seating system be provided? For example, a patient received a K0848 (Group 3 Standard power wheelchair [PWC]) which was billed and paid in 2010; however, due to a change in medical condition now requires a power tilt system. The manufacturer of the wheelchair has a retrofit kit that allows a tilt system to be added to the existing no power option base at a significantly lesser cost than providing an entire new chair. The recovery auditor is now recouping money stating the wrong wheelchair base was provided in this scenario. What can providers and the DME MACs do to help the recovery auditor understand this issue?

Response: Suggest you contact the Medicare recovery auditor.

21. **(C) Please clarify, when the patient has a progressive disease can the K0848 can be given at setup and then at a later date add on the tilt and/or recline because the patient does not really need it now and does not want it?**

    Response: The item(s) provided need to meet the beneficiary's need at the time the item(s) are provided. There is no Medicare policy provision to reimburse for item(s) based on future needs.

22. **(C) Why is the advance determination of Medicare coverage (ADMC) submission date becoming the 'initial date' of the power mobility equipment on a same or similar check? Shouldn't the 'initial date' of the equipment in Medicare's system be the date of delivery?**

    For example, when we submit an ADMC request, the date of the submission is then entered into Medicare's system as the 'initial date' of the equipment even though the beneficiary did not have the equipment on that date. Is the "temporary" ADMC initial date supposed to be changed to the delivery date upon receipt of the claim for processing?

    Response: While it is true that a date is created when the ADMC is processed, that initial date on the CMN should be changed to the actual date of delivery once a claim is processed. Please provide examples.

23. **(D) What information is available to providers in regard to any additional or different modifiers that relate to the round 1 recompete? If no information is available, when will it become available?**

    Response:

    - MM8181 – published 02/26/13 for "KY" modifier information
    - SE1035 Revised – published 08/22/12 for NCB modifier usage (other than KY)
    - MM7389 Revised – published 07/26/11 for grandfathered information and previous usage of KY modifier.
    - Durable Medical Equipment , Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Fact Sheets – located on CBIC Web site
    - CBIC Web site – Single payment amounts (SPA), CBA map, FAQs, etc…
    - CR6270 – list of Round 1 accessory codes and base codes that KE modifier would apply.

    In addition, in a December 9, 2013 CMS Webinar on the topic of the Round 1 Recompete, CMS indicated that an FAQ document would be published in the near future.

24. **(D) Providers are getting feedback that the physicians are not willing to put the date they sign the licensed/certified medical professional (LCMP) evaluation as their date of the completion of the face to face. This is because the patient may not actually be in the physician's office on that date. Physicians are taking the completion of the face to face literally. Can there be a clarifying line on the seven-element order that indicates there may be two dates, one for the date the physician signs the LCMP evaluation, and one that indicates when the beneficiary was seen in the office? In the event a physician utilizes the visit date in lieu of the signature date, will medical reviewers allow providers to accept this document and exercise the discretion to validate the seven-element order in spite of the technical variance?**

    Response: The date of the face-to-face evaluation is well-described in the power mobility devices LCD and in various publications from the DME MACs, including an article from April 2013 entitled "Face-To-Face Examination Date on Seven Element Order for Power Mobility Devices Scenarios."

25. **(D) Recently, a major provider of power mobility devices (PMD) went bankrupt. We believe this bankrupt provider has reached an 'agreement' with CMS, which will allow the bankrupt provider to send correspondence to those Medicare beneficiaries who are still under a capped rental program, documenting they are transferring title (ownership) of the PMD even though 13 months rental were not billed and paid.**

a. **What process does the DME MAC use to correct the common working file (CWF) to show the transfer of title and ownership to the beneficiary?**

b. **Providers are concerned that claims for repairs may still not be paid as the CWF will show the item to still be under capped rental. What information, if any, would the new supplier need to include with a repair claim?**

Response: Effective October 24, 2013, The Scooter Store (TSS) transferred titles to capped durable medical equipment (DME) rented to Medicare beneficiaries. Medicare beneficiaries now own this equipment. Medicare can pay for repairs to this equipment performed on or after October 24, 2013 if the contractor determines that the repairs are reasonable and necessary in accordance with Medicare regulations and program instructions.

Ostomy/Urological/Medical Supplies

26. (D) We follow the current external breast prostheses LCD when providing mastectomy bras to our customers and billing them to Noridian. We have recently begun to see billed claims paid at a reduced unit amount that is not stated in the external breast prostheses LCD. For example, we provide and bill 6 units of HCPCS L8000 and are paid for only four units (examples included) with the remaining two units denied. Has the processing of these claims changed? If there was a change, was this communicated to the supplier community?

Response: The external breast prosthesis LCD does not have a utilization parameter associated with code L8000. All supplies billed must be reasonable and necessary. The DME MACs expect documentation in the beneficiary's medical record to justify the item(s) dispensed.

Documentation/Education/Regulatory/Miscellaneous/Other

27. (B) Delivery: We were told in the past that if we had to send a partial shipment of product on one day and the remainder was delivered a couple days later, a date span was not newly required because of this scenario and that we could still combine the total and bill on the first date of service because billing twice in the same month would deny as duplicate. Is this correct? If this is not correct, please communicate the correct billing protocol for this scenario.

Response: A supplier may not submit a claim to Medicare prior to delivering all of the items for which he/she is billing Medicare. For parenteral and enteral supplies and glucose testing supplies which require span dates ("From" and "To" dates), the Medicare system allows for an overlap in claim span dates to accommodate the LCD requirements for refills and delivery. For billing purposes, each shipment of supplies requires a claim line—including span dates. For each shipment, the supplier is expected to have on file, request for refill documentation and proof of delivery documentation which supports items and quantities requested/delivered.

28. (C) In completing the forms that are provided to request an administrative law judge (ALJ) review, CMS-20034, there is a question on the form:

Did the beneficiary assign his or her appeals rights to you as the provider/supplier?

(If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment.)

In the event we are appealing a CO-denial, does the patient signing of the assignment of benefits meet this need?

Response: Yes

29. (C) Please provide clarity on the 30-day continued Part A stay evidenced in the CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 40.3.2. Suppliers are unable to know if or when a patient is going to be readmitted to a Part A facility; If the beneficiary is

readmitted within 30 days as described in the manual, and the stay becomes continued, how can suppliers get their claims paid for equipment that was delivered during the time the beneficiary was discharged and at home?

For example, a client was delivered a power wheelchair after discharge from a Part A facility because they require it to perform mobility-related activities of daily living (MRADL) at home. We delivered this equipment to her at home, but she unfortunately went back to this facility five days later. We are now unable to get our claim paid as it has denied for Part A eligibility on the delivery date even though we have confirmation the beneficiary was at home on this date.

Response: If the CWF inpatient record indicates that the beneficiary was in a place of service not considered to be "home", the DMEPOS supplier is not eligible for payment.

30. **(C) What measurements constitute a 'large' stage III or IV Pressure ulcer? LCD L11564, criteria 2 provides a very vague and general statement regarding the required size of a stage III or IV ulcer. Please clarify the measurements of a 'large' stage III or IV pressure ulcer in centimeters so that we may better follow this criterion.**

    Response: There is no published parameter for "large." There are numerous factors such as surface area, depth, undermining, tunneling, length of duration of the wound, etc. that are taken into consideration for large stage III or stage IV pressure ulcers. Suppliers should ensure that the documentation of these wounds is detailed and thorough.

31. **(C) In a time when Medicare is ever changing, who are providers to reach out to besides the Medicare Customer Service Help Desk which requires inquiries in writing and often takes up to and over a month to respond? Are Provider Outreach and Education associates individually available to assist providers directly? Providers have been told that there are no longer ombudsman-type liaisons to facilitate direct education.**

    Response: In an effort to continually improve the customer service provided to the supplier community—the Jurisdiction B DME MAC Provider Contact Center (PCC) uses a three-tiered system for answering supplier telephone inquiries. This system allows questions received from suppliers to be answered as quickly and accurately as possible. Calls are now answered by Level 1 and 2 customer care representatives (CCR) and by the provider relations research specialist (PRRS).

    All telephone inquiries will initially be answered by a Level 1 CCR. The Level 1 CCR can assist the supplier with a wide range of basic questions, primarily:

    - inquiries that cannot be answered by the IVR unit;
    - inquiries that do not require substantial research; and
    - inquiries that can easily can be answered during the initial call.

    Depending on the nature of the issue, calls may be referred to a Level 2 CCR. If the Level 2 CCR is not able to resolve the issue immediately, they have five business days from the day the inquiry is referred from Level 1 to respond. Level 2 CCRs provide additional experience and expertise, enabling them to answer more complex claim and CMN inquiries and in-depth financial and policy research.

    After the resources available in Level 1 and Level 2 have been exhausted, callers will be referred to Level 3 of the process, which is the PRRS. The PRRS has 45 business days from the day the inquiry is referred from Level 2 to respond, and will handle issues that require additional time and a higher degree of expertise and/or research.

32. **(C) Providers are receiving back to back development letters or additional documentation requests (ADRs) every month for the same patient and same code for catheters in Jurisdiction C. We have received documentation requests for September, October, and November for this same code requesting the same documentation. Is every claim under review, and is it possible to get claims exempted from the probe?**

Response: Every claim is eligible for review. Some DME MACs have processes in place to remove a beneficiary or supplier from further review for a period of time on a specific Healthcare Common Procedure Coding System (HCPCS) code, based on prior payment history or audit results; however, this is an individual DME MAC decision.

33. (C) Supply refills: When the patient is contacted/or contacts the supplier for refills, does the supplier have to document a specific number of supplies/items left or can the documentation be an approximate number of days remaining?

Response: Refer to the bulletin articles published by the DME MACs in August 2012 entitled "Items Provided on a Recurring Basis and Request for Refill Requirements – Revised – August 2012" and "Consumable Supplies – Request for Refills Documentation Requirements" published in November 2012.

34. (D) Provider, Enrollment, Chain and Ownership System (PECOS): Medicare Learning Network (MLN) Matters SE1305 Revised November 6, 2013, on page 9 of 12, the instruction states that:

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

In the Jurisdiction D Advisory Committee (DAC) Spring Provider Outreach and Education (POE) 2013 Update (when discussing the May 01, 2013 anticipated deadline for CMS to turn on the PECOS provider edits (which was later extended) we were advised that these would deny as a PR16.

a. Once the PECOS edits are turned on January 06, 2014, should providers expect to see a "PR" or "CO" denial when the claim does not pass the ordering/rendering provider PECOS edit?
b. If the beneficiary chooses not to change to a practitioner that IS registered in PECOS, can the provider obtain an ABN (marked option 3) and just NOT bill the claim?
c. In some cases the beneficiary may have alternate insurance that will consider the charges if Medicare denies on a PR denial. Could a provider obtain an ABN (option 1) and bill to get a PR denial? If not...Is there any way for the provider to bill and obtain a PR denial?
d. In the event that a beneficiary's physician has retired (or meets another exception) and will not be enrolling in PECOS, can claim denials be successfully appealed to bypass the PECOS edits?
e. Is it appropriate to bill claims where the physician is not in PECOS with an EY modifier to state the item has not been ordered by a qualified physician?
    i. If so, will the claims with the EY modifier deny not medically necessary (and therefore require an ABN)?
    ii. Will claims subject to Written Order Prior to Delivery and to the new Face-to-Face requirements deny as not covered when the EY is attached?

Response: MLN SE1305 addresses the full implementation of the referring/ordering physician edits.

35. (D) Medicare Cost and Risk Plans: Chapter One of the supplier manual states:

An alternative to the original Part A and Part B Medicare are the Medicare Health Plans, Medicare + Choice, or Medicare Advantage Plans, referred to as Medicare Part C. These are health plan options that are approved by Medicare and administered by private insurance companies. Claims for patients with Medicare Part C must be filed with the contractor of that particular plan and not to a Part A intermediary, Part B carrier, A/B MAC or DME MAC. Do not file claims for Part C to our office. Enrollment in Part C is optional.

These Medicare Advantage Plans can be classified as risk or cost. If a beneficiary has a cost Medicare Advantage Plan, they can choose who they want to be billed: original Medicare, or the Medicare Advantage Plan, but not both. Risk Health Maintenance Organizations (HMOs) replace Medicare coverage; Medicare is not secondary.

a. **Can you please explain the difference between these plans and the impact it has on a DME supplier?**
b. **How can a provider know if the beneficiary has a "cost" or "risk" plan?**
c. **Will this show up when eligibility verification is done?**
d. **Does the beneficiary elect their coverage at the time the plan is set up or can they choose on a claim by claim basis?**

Response: This question is not directed appropriately. There are available CMS fact sheets that explain the alternatives available to Medicare Fee-for-Service (FFS).

36. **(B) Does "Grandfathering" in the competitive bid world apply to customers that start a rental period while covered by commercial insurance (not in a competitive bid area) but enroll in Medicare and move to a competitive bid area a few months later?**

Scenario: Customer is in current PAP rental. On initial set-up/initial date of service, patient has commercial insurance and does not live in a competitive bid area. The customer becomes Medicare eligible a couple of months later and moves to a Competitive bid area. Can the home medical equipment (HME) provider that set the patient up with the equipment "grandfather" the patient through the rental period as long as the patient has seen their physician and documented evidence of OSA and is benefitting from the therapy after enrolling in FFS Medicare? Or because it is "new" to Medicare, do they need to switch to a contracted provider? Is a change in insurance treated as a "new initial order/new initial date of service"?

Response: When a beneficiary comes to Medicare, they are considered a new initial beneficiary for coverage purposes and must meet all Medicare policy requirements, including competitive bidding rules. Refer to bulletin article entitled "Medicare Eligibility and Documentation Requirements for DMEPOS items Obtained Prior to Medicare Eligibility."

37. **(D) Medicare *retroactive* payer change (in a CBA): It is a known fact that many patients with private insurance or Medicaid coverage become enrolled in Medicare FFS with retroactive eligibility and often the supplier is not informed until after the fact. We believe this scenario should garner special consideration regarding claim processing.**

If the beneficiary resides in a CBA and was provided a competitive bid (CB) covered item (e.g.; enteral nutrition and supplies) by a noncontracted CB supplier who had no knowledge of potential Medicare eligibility for the dates provided.

a. **How can we submit a claim to have a consideration of payment made for services provided in good faith?, and/or**
b. **How can we ensure a proper PR denial to hold the beneficiary liable? Note: Supplier does not have an ABN on file for these months since we were informed after the fact.**
c. **Are there any modifiers acceptable in this situation that will not hold the supplier liable?**

Response: The appeals process will need to be utilized in this situation

38. **(D) Providers have been experiencing problems with C2C Solutions, Inc. Providers are receiving denials stating information is missing when the documentation was clearly submitted. A recent example is a denial due to lack of physician's evaluation of the beneficiary for a lung disease or hypoxia-related condition. The signed history and physical record is from three days prior to the CMN date, chief complaint listed is shortness of breath and edema, and included in the discussion is that patient was in normal state of health until two days prior when the patient started noticing "increasing shortness of breath and increasing peripheral edema." Further discussion of the patient includes that "He does have a history of chronic obstructive pulmonary disease and is an active smoker."**

The concern here is that the determination is clearly wrong, as the hypoxia condition and lung disease is, indeed, stated. However, we cannot call to have the information reviewed again – the representatives with C2C will not acknowledge an error and simply state to go the next level (ALJ – which is said to be backed

up by approximately 28 months). It appears that the auditors are clearly NOT reading ALL the records that are being sent, yet maybe only reading a small portion to yield a denial.

In another example, the appeal for an E0601 initially denied as not having documented a face-to-face (F2F) prior to the sleep study. We were able to obtain the medical records from five days prior to the sleep study that states the chief complaint is a discussion of the overnight oximetry, stating that the patient is drastically fatigued with daytime somnolence, with OSA noted in the assessment and plan. C2C denied the appeal "because the submitted information did not include documentation of a face-to-face evaluation for signs and symptoms of sleep apnea by the treating physician prior to the sleep study…"

(These examples are indicative of a global trend that we see emerging with an increase in denials citing missing documentation that is clearly included with the appeal).

a. **Is there a complaint procedure available?**
b. **Who, specifically, is responsible for educating and monitoring auditors?**
c. **In these cases, where an obvious oversight by the auditor has happened, can these be reviewed without having to go through the ALJ?**

Response: Supplier should refer question to C2C.

PDAC

39. (C) Has there been any discussion about developing additional actuator codes to account for the different types of actuators necessary to operate the different technologies on power wheelchairs? Having one HCPCS code and one allowable for an array of different actuators creates a challenge for providers in some instances as the cost of certain actuators is more than the single allowed amount.

Response: Suggest requestor submit an application to the CMS HCPCS Work Group for a new code.

Diabetic Monitoring and Supplies

No questions submitted.

CEDI

No questions submitted.

Open Action Items/Status Update/Unresolved Issues

40. (C) Our question pertains to the 'Respiratory' question Jurisdiction C Council submitted for the April 2013 Q and A and the answer we received. Per the Q and A, under Respiratory, question #5 below, the statement in the 'Policy Specific' section contained a clerical error (reference to date of service being the initial date of need). However, to date the policy has not been updated. Question 5 of the April 2013 Q and A states:

Question: Do the oxygen testing and the physician evaluation have to occur within 30 days prior to the date of the initial certification/need (as established by the physician dispensing order) or does the oxygen testing and physician evaluation have to occur within 30 days of the date of service?

Response: The oxygen testing and physician evaluation have to occur within 30 days prior to the date of initial certification/need. The statement in the Policy Specific Documentation section contains a clerical error. The DMDs will revise the LCD to read (see red correction) as below:

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS (NCD 240.2)

Documentation for initial coverage requires information in the medical record showing:

- *Evidence of qualifying test results done within 30 days prior to the initial date; and,*
- *Evidence of an in-person visit with a treating physician done within 30 days prior to the initial date*

Can we get an updated timeframe as to when we should expect the correction?

Response: The update has been made.

41. **(ALL) Why are providers being remitted the competitive bid allowable for accessories furnished on a complex rehab power wheelchair even when we bill with the KY modifier? Per the Social Security Act Section 1847, Group 3 (or higher) complex rehabilitation power wheelchairs and their accessories have been carved out of the competitive bid program and therefore accessories used with these chairs should not be paid at the single payment amount. When do the MACs estimate a system fix for these claims? In the interim, how are the MACs advising suppliers to obtain the correct reimbursement rate?**

    Response: Based on system logic contract suppliers are receiving the SPA and noncontract suppliers are receiving fee schedule (FS) amount. Refer to MLN 8181: claims will be paid for competitively bid (Round 2 or subsequent Round) wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with certain noncompetitively bid wheelchair base units at the fee schedule rate, when billed by a noncontract supplier with a "KY" modifier.

42. **(ALL) Face-to-face: As authorized prescribers, Medicare allows nurse practitioners (NP) and physician assistants (PA) to sign orders. With the new face-to-face guidelines it states that any face-to-face notes done by someone other than a physician must be co-signed by a physician. In many rural areas a nurse practitioner or physician's assistant often practices without direct supervision (as allowed by state law). If suppliers are required to wait for the documentation to be co-signed before delivery, it could cause delay in patient treatment. In addition, if we are able to dispense prior to the notes being cosigned but not bill, it can result in a delay in payment. The requirement for a co-signature seems to be contradictory to the basic instruction in the manual.**

    What action can we, as suppliers, take to have this guideline reviewed and possibly rescinded?

    Response: Question should be addressed to CMS.

43. **(ALL) Face-to-face: How can providers be assured that recovery auditor and zone program integrity contractor (ZPIC) will not audit providers for the dates of service prior to future enforcement of the face to face requirement date?**

    Response: Question should be addressed to CMS.

44. **D) Teflaro (injection, ceftaroline fosamil, 10 mg) was assigned the J-code J0712 on January 1, 2012. Our company billed J0712 to Medicare, trying to get a denial in order to bill the secondary payer correctly; however, our claims to Noridian are being rejected.**

    We have been told by Noridian to use the generic HCPCS code J3490. The secondary payer needs the correct code (J0712) and matching denial to be able to price it correctly and process it.

    Whose responsibility is it at the Medicare contractor level to update J-codes for injectable medications?

    Response: Jurisdiction B has processing instructions to deny these as noncovered.

    Jurisdiction C has processing instructions to deny these as noncovered.

    Jurisdiction D has updated logic dated 11/25 to all J0712 to not reject but rather process and deny.