CENTERS for MEDICARE & MEDICAID SERVICES

AdminaStar Federal

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Region B Council A-Team Questions
Sorted by A-Team
September 2006

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. TriCenturion and Q2 Administrators have provided input on questions pertaining to Medical Policy, Benefit Integrity and Reconsiderations denoted with an *.

Please note: As of March 1, 2006, TriCenturion was granted Program Safeguard Contractor (PSC) responsibility for Region B DMERC. PSC responsibilities include Medical Policy, Medical Review, and Benefit Integrity. Please refer to our Website www.adminastar.com, TriCenturion's Website www.tricenturion.com, Q2 Administrators' Web site www.Q2A.com or visit the Centers for Medicare & Medicaid Services (CMS) Website www.cms.hhs.gov for recent updates.

Home Medical Equipment

1. Continuation to question 18 from June Region B Council question: If the second provider provides a piece of equipment on the 13th month, not realizing 12 months were previously paid; can the provider pick up the equipment?

   Yes, the supplier may pick up their equipment if they find that the patient had previously rented the same capped rental item. Capped rental dispensed on or after January 1, 2006, are considered to be owned by the supplier until the 13th rental payment is made. In the situation where the patient opts to change suppliers, the Medicare program will not allow for a new capped rental period. Patients in this scenario should be encouraged to try and work with the previous supplier for the last rental payment.

2. When Medicare is secondary, and the Primary Insurer purchases an item that Medicare classifies as a capped rental item, how does Medicare process the secondary payment (claim billed as purchase)? We recently asked a Medicare CSR and were referred to the Region B Council Q&A from Sept 2004, question #18. This question was answered stating that even though the claim was submitted and paid by the primary insurer as purchase, the provider should bill Medicare with rental claims, dividing up the primary payment and applying appropriately to the monthly claims.

   The Medicare payment category (purchase, capped-rental, etc.) determines how Medicare billing and payment must be done for Medicare claims. In cases where Medicare is the secondary payor, if the DMEPOS item is purchased by the primary insurance, the DMEPOS item must be billed to Medicare as purchase.

3. We have a signed ABN from a customer stating that they know an item will likely be denied by Medicare, because they already have same or similar equipment. We bill the claim with a GA modifier. Will a GA modifier always generate a PR category denial?

No, if the claim is denied for medical necessity or for same/ similar equipment, then a PR category denial should be generated when the GA Modifier is submitted. If the claim is denied for any other reason the supplier will receive a CO category denial when appropriate.

Enteral/Parenteral/IV Therapy
No Questions

Respiratory Care Equipment/Oxygen Therapy

4. Currently, if an E0470 is billed and these criteria are not met but the coverage criteria in the DME MAC policy for CPAP are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601. The DME MAC policy also states that if an E0471 is billed and the criteria for an E0470 device are not met, it will be denied as not medically necessary. With the E0471, E0470 and the E0601 now in the same payment category, if an E0471 is billed and the criteria for an E0470 device are not met, but the criteria in the DMERC policy for a CPAP are met, will the DME MAC consider payment based on the allowance for the least costly medically appropriate alternative, E0601?

   ***DME MAC Medical Directors will update Local Coverage Determination to allow downcode. Please refer to the LCD for Respiratory Assist Device on the TriCenturion Web site at www.tricenturion.com**

5. If the answer to the above question is yes and an E0471 is downcoded to an E0601, will the continued usage call requirements for the CPAP apply, or would the RAD documentation (physician certification and beneficiary statement) be required?

   ***Apply compliance check based upon item provided not based upon downcode.**

6. In the Region B Council Questions from 3/16/06, the answer to question #15 states that "informal testing done in a physician's office does not qualify as a legitimate test". Please define "informal testing"? Does this mean that suppliers can not accept any test done in a physician's office?

   ***Question #15 from the March 2006 Region B Council Q&A is in regards to exercise oximetry testing. Exercise Oximetry Testing is a real lab test (i.e. it has standards and rules about how it should be done so that the testing is standardized and the results are therefore accurate, reproducible, verifiable, and reliable). Our experience is that physician offices generally are not equipped to perform this type of testing under standardized conditions, such as would be found in a proper lab environment. The LCD's reference to "informal testing" refers to a variety of actions i.e. the practice of exercising a patient in a non-controlled fashion and performing an incomplete set of tests in a single testing session. Therefore, informal testing done in a physician's office would not qualify as a legitimate test.**

7. Are oximetry test conducted in a nursing home acceptable as long as the patient was in a Part A bed at the time of the test?

   ***Assuming the SNF is a qualified provider of laboratory services, yes.**

8. Can a provider bill for an A7030 (full face mask) and A7031 (face mask interface replacement) for the same date of service and get paid or will the A7031 deny?

   This inquiry has been elevated to TriCenturion for additional research and a response.

9. Question # 2 on the Old version of the 484 O2 CMN reads "Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home." The answer choices for this question are "Y" or "N".

   Question #2 on the new version of the O2 CMN reads "Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?" The answer choices for this new question are 1, 2, or 3.

   Currently the 837 maps question # 2 as a Y or N answer to transmit to the DMERC. We have two questions:

   1) Can we assume that a "Y" should be indicated when the physician circles either 1 or 2 as a response and an "N" should be indicated when #3 is given as a response?

      No, on the current electronic CMN 484.02 in the 4010A1 format, question 2 is mapped to the 2400 loop (DME Condition Indicator) CRC02. This will not change when version 484.02 of the Oxygen CMN is submitted.

      On the new electronic CMN 484.03 in the 4010A1 format, question 2 must be mapped to the 2440 loop. The 2440 loop will be created with an LQ segment identifying the CMN form number and an FRM segment to provide the response to Question 2. The answer to Question 2 must be in the FRM03 element with "1", "2", or "3". The old responses of "Y" or "N" cannot be used for CMN 484.03.

      For example, if the answer to CMN 484.03 Question 2 is "3 - Under other circumstances", the 2440 will be created as:
      LQ*48403~
      FRM*23~**
      Where
      FRM01 = CMN 484.03 Question number
      FRM02 is blank. This is only for "Y" or "N" CMN question responses
      FRM03 = 3 (the response to CMN 484.03 Question 2)

Please refer to the revised handout titled CR4296 New CMNs Tech Guide, page 2 (484.03 Oxygen CMN).

2) Will EDI be changing any of the current 837 mapping to coincide with the changes to the new CMN forms? If so, when can we expect these revisions to take place?

Yes, changes are mandated by CMS. Change Request (CR) 4296 must be implemented by all DME MACs and DMERCs for the October 2006 release. Programming has been completed by the standard system maintainer and DME MACs and DMERCs are currently testing the changes. All programming will be in production on October 1, 2006.

Either the old or new CMNs can be used on claims submitted after October 1, 2006. Effective January 1, 2007, only the new CMN versions will be accepted.

Prosthetics/Orthotics
No questions

Rehab Equipment
New requirements of the Power Mobility Device policy indicate that the supplier must prepare a written document, termed a "detailed product description" that lists the specific base, HCPCS code and manufacturer name/model, and all separately billable options/accessories. For claims with dates of service on or after 8/24/06, the supplier must list their charge and the Medicare fee schedule allowance for each separately billed item. If there is no fee schedule allowance, the supplier shall enter "not applicable". The physician must sign and date the detailed product description and the supplier must receive it prior to the delivery of the power chair or POV **(the following 4 questions are related to the new requirements for Power Mobility Devices).**

10. Suppliers are required to obtain two signed and dated documents (prescriptions) from the physician. If one of the prescriptions meets the stated requirements of the "detailed product description", can it serve to act as both the prescription and the detailed product description in lieu of having the doctor sign a third document? If so, can a combination of documents signed and dated by the physician meet the requirements of the detailed product description or must it all be contained on one form?

***Suppliers are required to obtain only one prescription and the documentation of the face-to-face exam. It is unlikely that the prescription will contain sufficient detailed information. This document, "detailed product information" replaces the detailed written order and Certificate of Medical Necessity (i.e. Section C) that was required in the past.**

11. Policy states that a detailed order must list the specific power chair being ordered. Does this refer to the specific code or the manufacturer and/or the specific model? If it is the manufacturer or the model, what does the supplier do if it is necessary to change the specific chair within a HCPCS code category?

***The detailed product must accurately describe the item(s) provided. If last-minute changes or substitutions are made the documents must be updated/revised accordingly.**

12. Does the specificity noted above extend to the specific accessories? For instance, cushions or backs within a specific HCPCS category or chest supports from different manufacturers?

***Yes, the detailed product information must accurately describe all item(s) provided.**

13. If a Medicare patient wants to purchase a wheelchair as cash and carry item knowing they do not qualify for Medicare coverage, does the provider need to have an ABN signed? Does the provider need to submit the claim to Medicare?

The Medicare Benefit Policy Manual, Chapter 15, §40 states in pertinent parts below:

40 - Effect of Beneficiary Agreements Not to Use Medicare Coverage

> **If an item or service is one that Medicare may cover in some circumstances but not in others, a non-opt-out physician/practitioner, or other supplier, must still submit a claim to Medicare. However, the physician, practitioner or other supplier may choose to provide the beneficiary, prior to the rendering of the item or service, an Advance Beneficiary Notice (ABN) as described in the Medicare Claims Processing Manual Chapter 30. (Also see §40.24 for a description of the difference between an ABN and a private contract.) An ABN notifies the beneficiary that Medicare is likely to deny the claim and that if Medicare does deny the claim; the beneficiary will be liable for the full cost of the services. Where a valid ABN is given, subsequent denial of the claim relieves the non-opt-out physician/practitioner, or other supplier, of the limitations on charges that would apply if the services were covered.**

In the scenario described above, it is suggested that the supplier secure an ABN outlining the specifics as to why the Medicare patient does not qualify the wheelchair being purchased.

Ostomy/Urological/Medical Supplies
No questions

Diabetic Monitoring and Supplies
No questions
Documentation/Regulatory/Miscellaneous:

14. Does CMS have any language that prevents providers from selling products for cash and carry below the Medicare allowable to non Medicare customers?

This inquiry has been elevated to TriCenturion and is pending clarification from the Benefit Integrity staff.

Other

15. Redetermination Form: There is no place to indicate DOS (multiple), document numbers, etc. How does DMERC know what claims you want redeterminations on? The form, also doesn't ask for provider numbers.

We are in the process of reposting the "original" redetermination form on our Web site. If suppliers have copies of the "original" form, AdminaStar Federal will accept redetermination request on old forms.

16. Receiving a copy of the hearing case file was standard procedure in the past. When going to Q2 Administrators for reconsideration, is there anyway for suppliers to request a copy of the case file?

***The case file mainly contains information already in the possession of the appellant, such as the claim information, the redetermination request, any documentation you submitted at the initial determination/redetermination, the redetermination decision letter, etc. Any "missing information" referred to in a redetermination letter is indicating that there was something you should/could have submitted that was necessary to determine proper coverage. If the supplier has concerns regarding this "missing information", the best source would be to contact the Medicare contractor and identify what to do next time or before proceeding with a Reconsideration request to the QIC without the information. Ultimately, in the regulations creating the new Reconsideration process, there is no procedure to send the appellant a copy of the evidentiary case file.**

17. Will Q2 Administrators expand their process in the near future to allow us to request telephone reconsideration?

***Regulations at 42 CFR Section 405.968.a.1 indicates that a QIC reconsideration consists of an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim. This on-the-record review evaluates all documentation presented by the appellant. The more complex the case, the more critical role is played by documentation**.

18. When we receive our denials from Q2 Administrators the bottom of the letter states the appellant cannot submit any additional evidence to ALJ, just what is currently on file. Please elaborate on this rule.

***Per the regulation at 42 CFR sections 405.956.b.8 and 405.966.b, all evidence that is not submitted prior to the issuance of the reconsideration will not be considered at an ALJ level, or made part of the administrative record, unless the appellant demonstrates good cause as to why the evidence was not provided prior to the issuance of the QIC's reconsideration. The intent of this regulation is to encourage early submission of any and all pertinent documentation to support the service under appeal**.

19. Are suppliers required to send a manufacturer price sheet with every Reconsideration when there are items that are non-fee schedule being reviewed (K0108, E1399)? Can Q2 Administrators base a denial not on medical necessity but on the absence of a manufacturer price sheet?

***If in their initial determination and their Redetermination decisions, the DME contractor raised the issue of reimbursement documentation, the QIC evaluates that issue. If the service provided is billed (and denied) using generic code such as K0108 or E1399 (commonly referred to as an NOC code) and the identity of the item, coverage or medical necessity of the item, or pricing of the NOC billed item is an issue at the redetermination level, then yes you need to submit any information necessary for the QIC to evaluate the specific issue. This is essential for the QIC to render a full and impartial decision on the services reviewed.**