National Government Services

8115 Knue Road
Indianapolis, Indiana 46250-1936
www.NGSMedicare.com

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Medicare

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Region B Council DME MAC 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 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, or visit the Centers for Medicare & Medicaid Services (CMS) Website www.cms.hhs.gov for recent updates.

Enteral/Parenteral/IV Therapy

1. Please document what Claim Adjustment Group and Reason Code is returned on a Standard Remittance Advice, an Explanation of Medicare Benefits, and in the X12N 835 remittance advice when a claim is submitted with HCPCS home infusion therapy per diem codes (e.g. S9502 for anti-infective Q8 hours) by a supplier that knows the claim will not be paid by the DME MAC or DMERC under coverage determination, using the GY, GA or GZ modifiers.

   The example above uses a Temporary National Code. S codes are used by the private sector and Medicaid programs to report drugs, services, and supplies for which there are no national codes but for which codes are needed to implement policies, programs, or claims processing. When these codes are submitted to Medicare a PR/96 denial is issued because these are Medicare non covered codes.

Respiratory Care Equipment/Oxygen Therapy

2. Regarding questions #4-5 on the Q&A from 09-06, Region B gave different direction than Region C in response to the same questions and we would like to get clarification. If the patient did not qualify for the higher product, why would we hold the patient to the continued usage standard of the product that he/she did not qualify for? The logical action would be to ascertain the patient's continued usage for the equipment he/she qualifies for (in this case, the E0601). Region B states- “Apply compliance check based upon the item provided not based upon the down code.” Region C states- If an E0471 is down coded to an E0601, the call requirement for the CPAP would apply.

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The PSC for Jurisdiction B responded to questions 4 and 5 of the September FAQ. For clarification purposes Suppliers should maintain documentation based on the item provided and in use by the beneficiary.

3. When a nebulizer drug is ordered, filled and shipped, and the order subsequently changes or the beneficiary uses a portion of the shipment - are we entitled to bill the original shipment?

   Yes, The Local Coverage Determination (LCD) for Nebulizers states that for an item to be covered by Medicare a written signed and dated order must be received by the Supplier prior to claim submission. A new order is required if there is a change in the type of solution dispensed or in the administration instructions. Payment will be considered based upon the written order for each claim submission.

4. When a CPAP is being replaced after numerous years because the equipment is broken beyond repair and is 13 years old and private insurance purchased it prior to Medicare eligibility, claims are being denied as same/similar. Medicare only has a CMN on file because of justifying the medical necessity of supplies and never actually purchased a CPAP. Should we use an RP modifier?

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

Rehab Equipment

5. If patient does not want flat-free inserts or a seat belt with the initial Power Wheelchair (PWC), then decides later to add flat-frees or the seat belt; are they billable? Does it matter when they are added?

   The coding guideline section of the PWC policy outlines the PWC Basic Equipment Package. Each PWC is required to include all of the listed items on initial issue. The policy instructs that there should be no separate billing or payment for the items at the time of initial issue unless there is noted exception. The policy does not provide an exception other than the billing of the initial date for the items described above. Suppliers are encouraged to document that the beneficiary did not want the items at the time of initial issue and upon delivery of the items after the initial date.

6. The KX modifier is now required on all Power Mobility Device (PMD) base and option codes if medical necessity is met. How should suppliers submit the fifth modifier on the claim (i.e. K08??NUKHBPKXGA)?

   In modifier overflow situations Suppliers should utilize Box 19 as outlined in Chapter 5 of the Jurisdiction B DME MAC Supplier manual.

   Please note: Jurisdiction B DME MAC Supplier Manual Chapter 14- Pricing and Overpayments will be updated to reflect Change Request 5010 "General Provider Education for Changes in the Payment for Oxygen Equipment and Capped Rentals for Durable Medical Equipment (DME) Due to the Deficit Reduction Act (DRA) of 2005" For claims with an initial date on or after January 1, 2006 suppliers are no longer required to give beneficiaries a purchase option in the tenth month of rental. HCPCS Modifiers BP, BR, and BU should not be submitted. Suppliers should use the BP, BR, and BU modifiers with respect to capped rental periods that began prior to January 1, 2006.

7. PMD policy calls for the use of the KX modifier to indicate that medical necessity documentation is complete and valid for the product/code billed. If the patient qualifies for a Group 2 PWC, but we provide a Group 3 PWC, how do we bill the claim? Do we bill the Group 3 PWC code (as provided) without the KX modifier?

   Yes, Suppliers should bill the DME MAC for the item that was provided.

   Or do we bill the Group 2 code that the patient actually qualifies for, with a KX?

   No, **The Power Mobility (PMD) Local Coverage Determination (LCD) outlines that if a Group 3 Power Wheelchair (PWC) is provided and the listed criterion is not met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC. The Documentation Section of the PMD LCD outlines the use of the KX modifier:**

   A KX modifier may be added to the code for a power mobility device and all accessories only if one of the following conditions is met:

   1. **If all of the coverage criteria specified in this LCD have been met for the product that is provided; or**
   2. **If there is an affirmative Advance Determination of Medicare Coverage (ADMC) for the product that is provided,: or**
   3. **If a Group 4 PWC is provided and if all of the coverage criteria for a comparable Group 3 PWC have been met.**

8. Will the DME MACs or the PSC issue revised language for the purchase option letter for power wheelchairs? If not, or if not for awhile, is it acceptable for providers to revise our letters to adjust for the capped rental policy change (take out the reference to the 10th month letter, omit the language about capped rental/maintenance, clearly state 13 months rent to purchase?

   The CMS Internet Only Manual (IOM) Publication 100-04 The Medicare Claims Processing Manual chapter 20 section 30.5 outlines the 10th month option letter in regards to a 15 month rental payment period. Change Request 5010 states that Suppliers must transfer ownership of the equipment in the 13th month. When the aforementioned manual changes are finalized contractors will be instructed to educate about the changes regarding the purchase option letter for capped rental items.

Documentation/Regulatory/Miscellaneous

9. It is our understanding that as a nonparticipating provider, we can choose to accept or not to accept assignment on a claim-by-claim basis. If we have multiple equipment set up on the same day and we accepted assignment on all equipment when it was set up, can we subsequently reverse assignment on a piece of equipment while continuing to accept assignment on the others?

   The Jurisdiction B DME MAC Supplier Manual Chapter 3 states that a nonparticipating supplier may not file assigned claims for some items and nonassigned claims for other items when they were provided to the same beneficiary on the same date. Once a claim has been filed as assigned, it may not be changed to nonassigned without the consent of both the beneficiary and the supplier. The notice to rescind must be received by the DME MAC prior to payment determination. The CMS IOM Publication 100.04 Chapter 1 section 30.3.2 states:

   > **A nonparticipating supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating supplier does not accept assignment, and is also not precluded from billing the patient for services that are not covered by Medicare. However, a supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. When a carrier becomes aware that a supplier is fragmenting his/her bills, it must inform him/her that this practice is unacceptable and that he/she must either accept assignment for, or bill the enrollee for, all services performed at the same place and on the same occasion.**

10. How does Medicare establish new codes? Specifically, the low-profile or button G Tubes. Other payer sources have developed modifiers that indicate that we are providing the low profile devices and pay according to the type of g tube being used.

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) establishes coding for equipment and supplies. Manufacturers or suppliers may write or call the SADMERC to request a new HCPCS code. The SADMERC address and helpdesk telephone number are provided below.

Please include the following information with your request.

The Manufacturer Name
The Product Name
The Model and/or Product Number
A Complete Description of the Product
Details explaining if the Product is being provided as an initial service or as a replacement.

SADMERC
P.O. Box 100143
Columbia, SC 29202-3143

SADMERC Helpdesk: 1-877-735-1326

11. For Certificates of Medical Necessity (CMN) status on the Interactive Voice Response System (IVR), are the CMNs that are loaded only CMNs that qualify for coverage? Or is every CMN loaded, even for claims that were denied?

Only payable CMNs are available through the IVR. The October 2006 version of the IVR User Guide is now available on the AdminaStar Federal website. The CMN Status and Eligibility chapter provides information about accessing CMN information through the IVR. Option 2 will allow suppliers to obtain CMN Status and Beneficiary Eligibility information. The IVR user guide is available on the AdminaStar Federal Website at:

http://www.adminastar.com/AboutUs/ContactUs/Telephone/IVR/DMERCProvider.html