National Government Services

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Medicare

Jurisdiction B Council A-Team Questions April 2007
Sorted by A-Team

Disclaimer: The Jurisdiction 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, or visit the Centers for Medicare & Medicaid Services (CMS) Website www.cms.hhs.gov for recent updates.

Home Medical Equipment
No questions

Enteral/Parenteral/IV Therapy
No questions

Respiratory Care Equipment/Oxygen Therapy

1. We have oxygen customers that were enrolled in Medicare Advantage Plans when the initial CMN's were done. Some of these patients are opting out of the Advantage Plans and back to FFS Medicare. These claims are rejecting with a 173 denial because Medicare has no Certificates of Medical Necessity (CMNs) on file. Can this be corrected through a CMN review?

   The Local Coverage Determination for Oxygen and Oxygen Equipment states in pertinent part:

   For Initial Certifications, the blood gas study reported on the Certificate of Medical Necessity (CMN) must be the most recent study obtained prior to the Initial Date indicated in Section A of the CMN and this study must be obtained within 30 days prior to that Initial Date. There is an exception for patients who were on oxygen in a Medicare HMO and who transition to fee-

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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.

Appeal rights are not granted for claims rejecting with ANSI code CO-173 (Payment adjusted because service was not prescribed by physician). As instructed by the LCD, suppliers must resubmit these claims with the appropriate CMN attached.

2. When will they publish all the fees for oxygen supplies (i.e., christmas trees)? Are they waiting until it is closer to the 36 months?

   The Centers for Medicare & Medicaid (CMS) has not published any information regarding the fees for oxygen supplies for patient owned equipment. As soon as the fees are released from CMS, this information will be communicated to the supplier community via the Jurisdiction B DME MAC Web site and List serve.

   ***TriCenturion anticipates additional instructions from CMS closer to the 36 month cap being met.**

3. The LCD for oxygen states the following: Accessories used with a patient-owned system that was purchased on or after June 1, 1989 will be denied as non-covered. Do we need an Advanced Beneficiary Notice (ABN) signed from the patient to bill them privately for all supplies received after the 36 month cap?

   An Advanced Beneficiary Notice (ABN) is not required after the 36 month cap has been met. The Medicare provision for the coverage accessories for patient owned oxygen systems applied to systems that were purchased on or after June 1, 1989 and prior to the Deficit Reduction Act (DRA) of 2005. Once the 36 month cap has been met, the DRA of 2005 requires Medicare to continue to pay for reasonable and necessary services and maintenance that are not covered by a manufacturer's warranty. Medicare will continue to pay for gas and liquid oxygen contents for patients using stationary or portable oxygen tanks and cylinders after the beneficiary using that equipment owns it.

For additional information regarding the Deficit Reduction Act of 2005, please visit the Centers for Medicare and Medicaid Services Web site at: www.cms.hhs.gov.

4. If a patient did not under go the appropriate blood gas study (no oxygen testing was performed prior to patient being set up on oxygen), how can we get the CMN pass the front end edits? The front end edit kicks out the CMN since there is not value in the testing field.

   National Government Services, Inc is currently researching this issue. Claim examples have been received but not reviewed.

5. There appears to be a conflict between the documentation section, HCPCS section and the policy article regarding some CPAP/RAD supply codes. The policy article states: "Accessories are separately reimbursable at the time of initial issue and when replaced." However, some of the codes are specifically defined as "replacement parts." Respironics, Inc. has published a grid that shows codes such as A7033 for nasal pillows/cushions as a code that is billable with the initial dispensing of the unit and supplies. Provider Outreach and Education says that if the item is defined as replacement only it cannot be "unbundled" with the initial dispensing.

   The Policy Article for Continuous Positive Air Pressure System (CPAP) states that accessories are separately reimbursable at the time of initial issue and when replaced. However, reimbursement for HCPCS codes A7031, A7032, A7033, A7045, and A7046 are limited to replacement only. All other CPAP accessories that are not defined as a "replacement" can be billed with the initial CPAP claim.

   When billing for Respiratory Assist Device accessories, please apply the guidelines indicated above.

   The Respironics grid reference above does not take precedence over the Medicare payment policy for CPAP and RAD accessories.

6. Is there a recommendation for submitting Oxygen claims when Question #2 is answered "other circumstances"? If "other circumstances" is indicated, the claim is denied with CO-B5. Is there anything we can or should be doing preemptively so that this doesn't have to be sent down for review with medical documentation?

The Jurisdiction B DME MAC encourages suppliers to submit as much detail information as possible in the note segment of the electronic claim and in box 19 of the paper claim.

Prosthetics/Orthotics

7. Is there a limit as to how many are Mastectomy bras are allowed in a year? If there is a limit, is it January to December (calendar year) or 12 month time span (April 4, 2006 – April 3, 2007)?

   ***Traditionally 12 mastectomy bras per year is considered a reasonable, usual amount.**

   Suppliers are encourage to track units per calendar year (January to December).

Rehab Equipment

8. When we are billing for repair/replacement parts for a patient-owned (Medicare paid) power wheelchair, do we need to add a KX modifier (i.e., E2361NURPKX) for each line item? Does it matter when the power chair was purchased?

   The LCD for Wheelchair Options/Accessories states in pertinent parts below:

   When billing option/accessory codes as a replacement (modifier RP), documentation of the medical necessity for the item, make and model name of the wheelchair base it is being added to, and the initial date of service of the wheelchair must be available upon request.

   Each line item billed for repair and/or replacement parts for a patient owned power wheelchair, must be coded with an RP modifier indicating replacement and with a KX modifier indicating that the medical necessity documentation for the service is on file and available upon request.

9. Downcoding of PMD (i.e., Group 2 PWC to POV) has been occurring and now has lead to service questions. If a Group 2 PWC is downcoded to a POV will the DME MAC recognize and pay for service claims to the actual equipment delivered (PWC) versus the POV?

TriCenturion's bulletin article published in September 2003 titled, "*Repairs, Maintenance, Replacement & Delivery*", states the following:

"Repairs for patient owned equipment are covered if they are necessary to make the equipment serviceable. Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the patient."

In the scenario provided above, Medicare previously established that the patient qualified for the least costly medically appropriate alternative, POV. Medicare provisions would allow in this instance for the repairs of patient owned Group 2 PWC up to the replacement value of the least costly medically appropriate alternative value of the POV.

To view this article in its entirety, please visit the TriCenturion Web site at: www.tricenturion.com

Ostomy/Urological/Medical Supplies
No questions.

Diabetic Monitoring and Supplies
No Questions.

Documentation/Regulatory/Miscellaneous

10. Why is Medicare denying claims with a CO denial code when they are billed with a GA modifier? Example: When supplying replacement wheelchair items (such as K0099) more often than every 5 years for irreparable wear (vs. loss or irreparable damage) we obtain a signed ABN prior to providing the equipment. Medicare generally denies these claims with a CO-57 denial vs. a PR-57.

    The submission of a GA modifier does not guarantee an automatic Patient Responsibility (PR) denial. In the event the supplier/beneficiary does not agree with the initial claim determination, a redetermination may be requested with all appropriate documentation to validate the request for change in patient liability.

11. Can a wheelchair less than 5 years of age be replaced with a same or similar item and be reimbursed by Medicare? In reviewing Rev 51 Chapter 15 page 14 of Supplier Manual the reasonable lifetime of equipment is stated to be 5

years. It is also stated that replacement due to wear is not covered. On the same page the manual also states that "Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item." Please clarify.

A wheelchair less than 5 years of age can be replaced with a same or similar item and be reimbursed by Medicare if the documentary evidence submitted with the claim substantiates the following:

- **Medical necessity for the replacement is re-affirmed via a physician's order or CMN and,**
- **Documentation of the initial item being damaged beyond repair, lost, or stolen.**

12. Recently we have begun to receive EDI transmission rejects when we attempt to use ICD-9 codes in the E series. For example E878.9 Surgical operation and other surgical procedure as the cause of abnormal reaction of patient, or of later complication, without mention of misadventure at the time of operation. We submitted other non E Series codes on the claim as well. This ICD9 Code is valid in the published ICD9 code book. When we called the DME MAC Provider Assistance Line we were told the E878.9 was invalid (as of 12/30/2000) to be used with the HCPCS codes we submitted on the claim (B4035, B4152, and B9002). The ICD9 code book we use instructed us that they receive all their codes directly from CMS. Why would a code, which helps better define the patient's condition, be rejected on the EDI front end edits? The reject reason given is "Pointer 1 Dig Invalid" and "Header Dig 4 Invalid". Also, the Enteral Medical Policy does not contain a list of ICD9 codes which are invalid for use in billing enteral supplies. Also, we could find no published instruction stating E series codes are invalid for enteral supplies.

VIPS, the Medicare Processing System terminated the use of E-Codes for dates of service on and after January 1, 2001 based on CMS instructions. Change Request 2716 and 2891 states:

3 - E-Codes as Principal Diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification

(ICD-9-CM), January 1979, Volume l (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

The Medicare Claims Processing Manual Chapter 4, Page 10, 40.2.3 at http://www.cms.hhs.gov/transmittals/downloads/R53CP.pdf states:

If an E-Code is listed on a claim as the first, second, third or fourth diagnosis, the electronic claim will reject on the front end

CMS gives National Government Services a file that is loaded into our system. It lists the diagnosis codes, their effective date, and their term date. The file shows that E-Codes terminated in 2000. National Government Services, Inc is currently researching this issue.

13. Jurisdiction A has published a list serve stating that claims received March 23, 2007 and after with the BR, BU or BP modifiers will be denied unless the claim is for a Power Wheelchair. Does this instruction apply to suppliers submitting claims to the Jurisdiction B DME MAC as well?

    Yes, Suppliers must continue to use the BP, BR, BU modifiers for capped rental periods with initial dates of service prior to January 1, 2006. National Government Services is currently adding the BR modifier when capped rental paper or electronic claims are submitted without the BR modifiers. Effective April 6, 2007, NGS will no longer add the modifier to paper or electronic capped rental claims. Capped rental claims submitted without the required modifier will be denied with ANSI message 4.

    For additional information regarding the submission of the BP, BR, and BU modifiers, please visit the *What's New* section of the National Government Services Web site at www.NGSMedicare.com.

14. Is the Make, Model, Serial # and Supply Date required for all repair items or does Medicare keep a record of the chair after they have paid for at least one repair? If the chair is more than 1 year old, is a new detailed written order required for the base in order for Medicare to pay for the repairs? .

    When billing for the repairs of a patient owned wheelchair suppliers are required to document the medical necessity of the item being repaired, make and model name of the wheelchair base it is being added to and the initial

date of purchase. This information must be made available upon request. A new physician's order is not required for medically necessary maintenance and repairs.

15. For items provided under the new 13 month capped rental guidelines, if there is an interruption in payment and 13 consecutive months are not paid will providers have to send the additional claim to break-in-service (BIS) to extend the end date on the CMN

    Yes, suppliers will be required to submit their claims to BIS to extend the end date on the CMN.

16. If a capped rental item (i.e., manual wheelchair or CPAP) was provided and billed to traditional Medicare prior to Jan 1, 2006; and subsequently capped and maintenance and service was being paid, and later the patient switches to a Medicare HMO, what are the obligations of the HMO for that rental? Do they pay new rental claims? Or, must they pay the maintenance and service claims on the original schedule? Many Medicare HMOs refuse to pay the capped rental MS charges. Are there any CMS instructions to Medicare HMO Insurers specific to capped rental?

    The CMS IOM Publication 100- 16 Medicare Managed Care Manual, Chapter 4, §10.2 - Services of Non-contracting Providers and Suppliers states in pertinent part below:

    §10.2 – Services of Non-contracting Providers and Suppliers
    (Rev.23, 06-06-03)

    An MA organization must make timely and reasonable payment to, or on behalf of, the plan enrollee, for the following services obtained from a provider, or supplier, that does not contract with the MA organization to provide services covered by the MA plan:

    - **Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the beneficiary's health, as provided in §140 of this chapter;**

    - **Emergency and urgently needed services under the circumstances described in §140 of this chapter;**

- **Maintenance and post-stabilization care services under the circumstances described in §140 of this chapter;**

- **Medically necessary dialysis from any qualified provider selected by an enrollee when the enrollee is temporarily absent from the plan's service area and cannot reasonably access the plan's contracted dialysis providers. An MA plan cannot require prior authorization or notification. However, an enrollee may voluntarily advise the MA plan if they will temporarily be out of the plan's service area. The MA plan may provide medical advice and recommend that the enrollee use a qualified dialysis provider. The MA plan must clearly inform the beneficiary that the plan will pay for care from any qualified dialysis provider the beneficiary may independently select; and**

- **Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of 42 CFR Part 422) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.**

Payments to Non-contracting Providers and Suppliers

An MA plan (and an MA MSA plan, after the annual deductible has been met) offered by an MA organization generally satisfies its requirements of providing basic benefits with respect to benefits for services furnished by a non-contracting provider if that MA plan provides payment in an amount the provider would have been entitled to collect under original Medicare (including balance billing permitted under Medicare Part A and Part B).

Based on the Medicare regulations cited above, Medicare HMOs are not under any obligation or mandate by CMS to honor pre-existing capped rental agreements for beneficiaries who have chosen to enroll in to a Medicare HMO plan.

17. If we receive a 'same or similar' denial on a power wheelchair, when we send the denial to redeterminations, exactly what information should be submitted with the request? Should we just send the detail on why the previous wheelchair needed replaced (could not be repaired or modified)?

Suppliers are instructed to submit the following documentation with their redetermination request:

- **all pertinent medical documentation to support the need for the power wheelchair in question.**
- **documentation regarding the status of the same or similar chair in history indicating why the chair is no longer medically necessary for the patient.**

18. Medicare Learning Network Matters Article 5495 regarding MUEs states that units of service in excess of MUE criteria will be denied or suspended. In the case of enteral nutrition, where you cannot deliver ½ can, we have always rounded up. Will we now be denied, for billing excess units? Also, if a patient chooses to buy units in excess of the MUEs (for example, ostomy pouches) we can no longer offer the ABN?

    The expectation for the National Coding Initiative is to ensure that suppliers are providing Medicare beneficiaries with appropriate services. In cases where the patient requires one-half of a unit of service to complete the physician's order, it is expected that the units of service will be rounded up. This would not be deemed an excessive unit of service. However, if excessive units of service are rendered to a Medicare patient, the supplier is held liable for the charges denied as excessive. An Advance Beneficiary Notice is not valid for this reason.

    To view the MLN Matters article, please visit the CMS Web site at www.cms.hhs.gov.

19. Are immunosuppressive or anti cancer drugs ever covered in a place of service 31 or 32?

    The CMS IOM Medicare Claims Processing Manual, Chapter 7, SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule) §70 Drugs, states the following:

    70 - Drugs
    (Rev. 1, 10-01-03)
    SNF-536, SNF 536.1

Drugs and biologicals furnished to outpatients for therapeutic purposes that are self administered are not covered by Medicare unless those drugs and biologicals must be put directly into an item of durable medical equipment or a prosthetic device.

Exceptions to this rule are:

- **Self administered drugs administered in an emergency situation;**
- **Self-administered oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic;**
- **Self-administered anti-emetic drugs;**
- **Oral anti-emetic drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drug(s) be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent; and**
- **Immunosuppressive drugs furnished to transplant patients.**

Based on the regulation reference above, oral anti cancer drugs and immunosuppressive drugs are excluded from consolidated billing and therefore remain separately billable to the DME MAC when furnished to a beneficiary in place of service 31 or 32.

20. We bill Jurisdiction B for a pharmacy that services long term care facilities. The facility tells the pharmacy that these drugs should be billed to Jurisdiction B because they are a Part B benefit. The codes in question are J8521 and J0881. If we bill they are rejected for place service code. The facilities say they have nowhere to bill them to. So who gets the bill?

    See response to question #19. Requested examples from supplier to research denials.