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Medicare

Jurisdiction B Council A-Team Questions
Sorted by A-Team
November 1, 2007

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, the Program Safeguard Contractor for Jurisdiction B has provided input on questions pertaining to Medical Policy and Benefit Integrity. These questions are denoted with an *.

Home Medical Equipment
No questions submitted.

Enteral/Parenteral/IV Therapy
No questions submitted.

Respiratory Care Equipment/Oxygen Therapy
No questions submitted.

Prosthetics/Orthotics

1. Does Medicare policy provide any minimum limits on the time interval between fitting a patient with a preparatory (temporary) prosthesis and a definitive (permanent) prosthesis?

   SAMPLE CASE SCENARIO:

   A patient is initially fitted with a preparatory prosthesis such as L5540 (for a below knee amputation) or L6580 (for a below elbow amputation) for the purpose of evaluation and/or training. After the evaluation/training phase is completed, the final prescription specifications are written and the patient is ready to be fitted with a definitive prosthesis, such as a L5301 (for a below knee amputation) or L6935 (for a below elbow amputation); is there a minimum time frame

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(days/months) required between the delivery of a preparatory prosthesis and a definitive prosthesis?

***The Local Coverage Determination for Lower Limb Prostheses does not outline a time frame, however the expectation is that there is a relatively short period of time (1 – 3 months). If it took longer than 3 months to fit the patient with a definitive prosthesis, an explanation of the events that transpired should be documented in the patient's file (i.e. multiple temporary prosthesis, inpatient and/or outpatient records).**

2. When Medicare is the secondary payer, are suppliers of orthotic and prosthetic services who submit nonassigned claims limited to the amount they can balance bill the beneficiary, in the same way that non-participating physicians are restricted (i.e. balance billing cannot exceed the Medicare allowable by more than 15%)?

   SAMPLE CASE SCENARIO

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

Provider's Charge	$4,250.00
Primary Insurer's Allowance	$3,150.00
Primary Insurer's Payment	$1,575.00
Patient Balance	$2,675.00 (as reported on the Explanation of Benefits (EOB) statement from the primary payer

   Medicare Allowance for Procedure (L5321) $3,005.65

   Medicare Liability without regard to Other Insurance
   $3,005.65 X 80% = $2,404.52

   Beneficiary's Liability Considering Payment from both the Primary Insurer and

Medicare $2,675.00 - 2,404.52 = 270.48

(a) Is this correct? Would Medicare pay $2,404.52 to the beneficiary, leaving a balance to the patient of $270.48?

(b) Is the supplier permitted to bill the beneficiary for the remaining amount of $270.48?

(a) When Medicare is secondary, Medicare will pay the lowest of the following 3 formulas:

1. **Charge minus primary paid,**
2. **Amount Medicare would have paid if primary or**
3. **Higher of Medicare allowed or primary allowed minus the primary paid amount.**

(b) There are no special rules and/or regulations for nonparticipating physicians when billing as secondary.

Rehab Equipment

3. Is it required that the Power Mobility Device (PMD) supplier have a copy of the prescription that the physician writes to a therapist ordering an evaluation?

No, PMD suppliers are not required to secure a copy of the prescription that the physician writes to the therapist that is ordering the evaluation. However, PMD suppliers are required to obtain copies of the documentation from the ordering physician and therapist supporting the medical necessity of the item being provided. The documentation that is obtained within the supplier's files must support that there is <u>no</u> financial relationship between the supplier and the therapist.

4. Wide-spread audits: (a) Do/will suppliers receive any specific reasons if an audited claim was denied? (b) What 'education' will be provided to improve supplier's ability to comply and meet documentation requirements? Is there any mechanism to "audit the auditors"?

(a) **The Centers for Medicare and Medicaid Services (CMS) Internet Only**

Manual, Program Integrity Manual, chapter 3, §3.4.2, outlines the requirements for conducting a medical review and/or a benefit integrity review. Contractors are required to give a specific reason for denial and under the instructions of CMS the notification can be given via the remittance advice for suppliers and the Medicare Summary Notice (MSN) for beneficiaries.

(b) **The Medical Review (MR) and Benefit Integrity (BI) team utilize several avenues to educate suppliers. The method of education depends upon the results of the review. In cases where mass suppliers are affected by the findings of an audit, the MR, BI, and Provider Outreach and Clinical Education team will work together to develop educational articles which should be referenced as a supplement to or clarification of the Local Coverage Determination (LCD) and Policy Article. In cases where individual training or education is required, the MR, BI, and Provider Outreach and Clinical Education team will determine the best method and/or avenue for education. In addition, the supplier may be placed on a pre-pay review under the Progressive Corrective Action requirements.**

(c) **Yes, CMS utilizes several avenues to audit the performance of the Medicare Contractors. Annually, CMS will conduct Contractor Performance Evaluations (CPE) and the Medicare Contractor Provider Satisfaction Survey. It is the expectation of CMS that the Medicare Contractors maintain an internal compliance program consisting of self assessments, performance oversight, Comprehensive Error Rate Testing, and an educational training program, often referred to as the S.P.A.C.E program.**

For additional information regarding the Medicare Review and Benefit Integrity review, please see the CMS IOM Program Integrity Manual, Chapter 3, §3.4.2, Medical Review Denial Notices at www.cms.hhs.gov.

Ostomy/Urological/Medical Supplies

No questions submitted.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous

5. Has any thought been given to working with individual State Medicaid agencies on the use of modifiers? We encounter problems on crossover claims because Medicaid does not use the same modifiers, especially for equipment. Along those same lines, please address which modifiers we should be using in order to get a PR denial from Medicare. There are a number of products that Medicare does not pay for, but since they must be billed with a miscellaneous code, Medicaid requires a Medicare denial. We use a GY and put in the narrative that we are billing for a PR denial, along with the product description. We do not always get a PR denial. The same thing is happening on G-Tube claims. We have clients using a G-tube per month. We indicate the GY modifier on the 2nd and 3rd month claims, in order to be able to bill Medicaid, however we do not always get a PR denial and in fact many times the claims pay.

   Within broad national guidelines established by federal statutes, regulations, and policies, each state is responsible for the following:

   1. **Establishing its own eligibility standards, type, amount, duration, and scope of services,**
   2. **Type, amount, duration and scope of services covered,**
   3. **Setting the rate of payment for services and**
   4. **Administration of its own Medicaid program.**

   Medicaid operates as a vendor payment program. Each state has the option of paying suppliers directly on a fee-for services basis or through various prepayment arrangements such as HMO's. With federally imposed upper limits and specific restrictions each state has a broad discretion in determining payment methodology and rates for services.

   Modifiers for Medicare DMEPOS items are required coding pursuant to the instructions provided by the Medicare Claims Processing Manual, the National Coverage Determination, and Local Coverage Determinations and Policy Articles, all of which is governed by the Centers for Medicare and Medicaid

Services. Medicare will never fall secondary to Medicaid; therefore, it would be the responsibility of each state to align its coding requirements with the primary payers.

With respect to the scenario provided above, the GY modifier is being used correctly. Submission of the GY modifier is limited to items or services that are statutorily excluded from coverage, i.e., the item/service is not covered under any benefit category. The Medicare Program allows for the coverage of a gstrostomy tube (G-Tube) under the prosthetic benefit and therefore would not be excluded from coverage. Claims submitted for units of service greater than the maximum allowed per the Local Coverage Determination for Enteral Nutrition will be denied as not medically necessary. Suppliers will receive a contractual obligation denial (CO) for the excessive units of service. If the beneficiary was notified in advance of the possible denial due to the excessive units of service and the has properly executed the Advance Beneficiary Notice, the supplier may submit the claim with a GA modifier indicating such. A patient responsibility (PR) denial will be given indicating that the units of service are deemed excessive/medically unreasonable and necessary.

For detailed instructions on the use of an Advance Beneficiary Notice, please refer to the Jurisdiction B DME MAC Supplier Manual, chapter 9, *Advance Beneficiary Notice* located on the National Government Services Web site at:

http://www.adminastar.com/Providers/DMERC/medicalpolicy/suppmanualbychapters.cfm

6. Medicare Secondary Payer: If a Medicare beneficiary has an auto accident and if the accident/insurance policy is primary to Medicare for expenses related to the accident, but if the beneficiary has a pre-existing condition, diabetes for example, the auto policy would not be primary for those supplies. Eligibility shows Medicare as secondary to the auto policy.

   a. Does a claim for the diabetic supplies need to be submitted to the auto policy for denial before a claim can be processed by Medicare?

No, if the diagnosis on the claim is unrelated to the accident, it does not need to

be submitted to the auto insurer.

b. Every time?

Please see the answer to part A of this question.

c. When the auto policy benefits are exhausted, how does the Medicare eligibility file get updated to remove that information as a primary policy?

The supplier or beneficiary must provide a copy of the Personal Injury Protection (PIP) log that indicates the benefits have been exhausted. The supplier or beneficiary must supply that information to the Coordination of Benefits Contractor (COBC) directly or you can provide this information to Medicare and Medicare will communicate the information to the Coordination of Benefits Contractor (COBC). The COBC will update the patient's eligibility file with a termination date. Suppliers and/or beneficiaries can contact the COBC at: 1-800-999-1118.

7. A patient comes in and gets CPAP supplies periodically throughout the year. However, they do not meet the guidelines for coverage. Do we need to get an Advance Beneficiary Notice (ABN) each time the patient gets supplies or does a single ABN cover the extended course of treatment. And what is the time limit on a single ABN.

Per the instructions outlined in Change Request 2415, one year is the limit for the use of a single ABN for an extended course of treatment; if the course of treatment extends beyond one year, a new ABN is required for the remainder of the course of treatment. Suppliers are reminded that an ABN, once signed by the beneficiary may not be modified or revised. When a beneficiary must be notified of new information, a new ABN must be given.

8. We have been receiving PR4 denials on our rental equipment stating the claim needs a BP, BR or BU modifier. This type of denial is a result of the patient having a break in service and Medicare's records showing an initial date prior January 2006. For example, a patient receives a nebulizer on 6/14/05, returns the equipment on 2/1/06 and receives the equipment again on 5/11/07. Medicare's records are

showing the initial date as 6/14/05. The problem occurs when we set the patient back up and adjust our cap start date to bill out the correct amount of rentals. In this case, our records show a cap start date of 9/11/06 because of 8 previously paid rental months. Since Medicare's initial date is in 2005, your system is still requesting the use of the cap rental modifiers. How do we handle this situation since we did not ask for a new cap rental period? If Medicare's records are showing an initial date in 2005, can we allow the patient the option of keeping the item as a rental? Or, do we consider the item as being purchased because the cap start date is after January 2006?

The Jurisdiction B DME MAC has requested claim examples to research for a resolution.