National Government Services

National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

Medicare

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

Home Medical Equipment
No questions submitted.

Enteral/Parenteral/IV Therapy
No questions submitted.

Respiratory Care Equipment/Oxygen Therapy

1. When an overnight pulse oximetry test is conducted, is the date of the test submitted on the CMN the date the overnight test started, or the date the test finished? In most cases the bulk of recorded sleep oximetry data is taken on the date the test finishes. Which date is appropriate to use? When the patient testing is done as a hospital as an in-patient it effects the requirement of the test being done within 2 days of discharge.

   In the event of an overnight pulse oximetry that is done while the patient is inpatient, in preparation for discharge to home, the date should be when the test is completed.

2. For patients to qualify for 1 ½ times the fee schedule amount for oxygen on prescribed liter flows greater than 4 LPM, they must be tested on 4 LPM. Can the patient be tested on 5 or 6 LPM and still meet the coverage criteria for 1 ½ times the fee schedule as long as they are still below the 88% oxygen saturation level?

   The primary expectation is that the physician's order reflects the LPM provided. If the patient is tested on 5 LPM and the saturation level is at or below 88% and 6 LPM is ordered, as they are retested and meet the "greater than 4 LPM criteria" there should be an entitlement to the additional fee schedule amount.

Prosthetics/Orthotics
No questions submitted.

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Rehab Equipment

3. We are questioning documentation trail vs. visit trail on power mobility products. As we understand it, here is the process, start to finish, as outlined in the supplier manual.

    - Patient sees physician for Face-to-Face examination
    - Physician either completes report of Face-to-Face examination and signs and dates or recommends an OT/PT visit to complete the Face-to-Face examination.
    - Physician then signs off on Face-to-Face examination report.
    - Seven-element order is written.
    - Provider goes to assess patient for equipment needs to get equipment to patient w/ in 120 days of the signed Face-to-Face examination report. (A visit which cannot take place until they have received the Face-to-Face report)
    - Provider sees that positioning is necessary. (Doctor doesn't necessarily realize this when they complete the Face-to-Face or seven-element order)
    - Specialty evaluation is completed by outside provider (nowhere in policy is it stated that the physician needs to sign off on this evaluation)
    - Final detailed written order including all components to be provided is sent to physician
    - Power mobility is provided w/ in 120 days of initial Face-to-Face examination.

    Questions:

a. Is it required that the physician sign off on the specialty evaluation (needed for group 2 single power or dual and group 3) or is this just necessary to start the 120 days over? If the physician has written the seven-element order at the time of his/her face-to-face visit and then receives the specialty evaluation, do they have to re-write the seven-element order?

    As noted above, there is no requirement for the physician to sign off on the "specialty evaluation". The person performing the specialty evaluation must sign and date it. However, this would usually be done after the seven-element order has been completed and signed by the physician. In the event the **process of completing part of the face-to-face the PT/OT also completes** a "**specialty evaluation**" **the physician would only need to sign off on the face-to-face components (of the PT/OT exam) and this would be prior to the seven - element order. The date of that signature indicating the**

completion of the Face-to-Face should be the one indicated on the seven - element detailed written order.

b. During a recent teleconference (1/30/08) it was indicated that specialty evaluation must be signed before the seven-element order which contradicts the policy manual.

As noted above, there is no requirement for the physician to sign off on the "specialty evaluation". The person performing the specialty evaluation must sign and date it. However, this would usually be done after the seven-element order has been completed and signed by the physician

4. Please clarify the requirements for a supplier to employ an Assistive Technology Specialist (ATS) or an Assistive Technology Practitioner (ATP). Can the ATS/ATP be hired as per diems or as a contracted service (or as W-2 employees vs. 1099s)?

The requirement states that the supplier must employ an ATS/ATP that is directly involved with the wheelchair selection for the patient. There are no provisions in place limiting the type of employment to full time, part time or per diem.

5. HCPCS codes K0830 and K0831 fees have been removed from the fee schedule. Will these codes be reimbursed under the fee schedule allowance for HCPCS codes K0822 or K0823?

The March 2008 revision of the Local Coverage Determination for Power Mobility Devices states that a seat elevator is a noncovered option on a power wheelchair. Therefore, if a Group 2 Seat Elevator PWC (K0830, K0831) is provided and if all of the criteria (a)-(e) for a PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative Group 2 PWC without seat elevator. To view current and archived Local Coverage Determination and Policy Articles for Power Mobility Devices, please visit the National Government Web site at www.NGSMedicare.com click AdminaStar Federal, Jurisdiction B DME MAC and then Medical Policies.

6. We have received a call from a provider (DCN available upon request) regarding the rental of a manual wheelchair. The manual chair was rented with a DOS 12-28-07. A claim for a PWC was paid with a DOS 1-16-08. The claim for the PWC was paid by the DME MAC first, and the rental for the manual was denied because the

DME MAC already paid for a PWC. A level 2 CCR explained that this was done according to processing guidelines, where date of receipt drives payment. Shouldn't payment be driven by DOS especially in a case like this?

Document Control Numbers were requested to research this issue further.

7. The HCPCS Update for 2008 released new codes for power wheelchair accessories. However, there is no guidance as to coverage or payment rules. Will this be forthcoming?

The March 2008 publication of the revised DME Local Coverage Determination (LCD) and Policy Article (PA) for Wheelchair Options and Accessories address the coverage criteria and payment rules for the new power wheelchair accessory codes. The LCD and PA for Wheelchair Options and Accessories can be viewed at www.NGSMedicare.com click AdminaStar Federal, Jurisdiction B DME MAC and then Medical Policies.

8. The HCPCS Update for 2008 included narrative changes to HCPCS E2373. The new narrative excludes "including all related electronics". Does this mean a supplier can now bill separate for the related electronic?

In 2008, a new code that was created was E2313 - Power wheelchair accessory, harness for upgrade to expandable controller. As stated in the recently revised Wheelchair Options and Accessories (WCOA) Policy Article, this code describes "all of the wires, fuse boxes, circuits, switches, etc. that are required for the operation of an expandable controller." It is billed in addition to an expandable controller (E2377 initial issue, E2376 replacement). As defined in the WCOA Policy Article, a compact remote joystick (E2373) requires an expandable controller. Therefore, when a compact remote joystick is provided at initial issue, codes E2313 and E2377 representing "related electronics" are separately billable/payable. That is reason that the phrase "all related electronics" was eliminated from the revised narrative description of code E2373. When E2373, E2313, and E2377 are billed for a compact remote joystick, there are no other electronics that may be billed with codes E2399 or K0108.

9. The following are questions relating to the Jurisdiction B DME MAC Lunch and Learn PMD Q&As:

Question #18

Can the supplier produce a form for the physician to complete for the seven element order on?

RESPONSE:
No. A supplier cannot draft a form or template to have the physician date and sign. The physician must write, sign, and date the seven element order. The supplier can draft instructions about the requirements for the seven-element order to help educate the physician. However, suppliers cannot complete the information required in the order.

This is different than what Jurisdiction D allows?

In a Q&A from a PMD online workshop, Noridian provided the following:

Q8. It has been indicated that the order for the PMD must be on the physician's prescription pad. May suppliers have printed pads with their information for the physician to use? Is an order on a pad such as this acceptable?

A8. A detailed written order on a supplier's letterhead is not acceptable. A supplier can, however, provide the physician with a plain white form with the seven required written order elements noted as follows:

Name:
Description of item ordered:
Date of face-to-face:
Diagnoses/Conditions:
Length of need:
Signature:
Date:

Again, this must be on a plain piece of paper, not letterhead or with any reference to the supplier. NAS recommends that if you choose to provide the physician with this blank form, that you accompany it with a letter explaining what is needed in the written order. The supplier or biller can not complete any portion of this blank form. This was verified as acceptable with the Jurisdiction D DME Medical Director.

Jurisdiction D will allow a blank 7 element order (with no provider information or pre-filled information) to be given to the physician to fill in.
Can Jurisdiction B clarify their stance on this?

Jurisdiction B agrees with Jurisdiction D that, for the 7 element order, it would acceptable for the supplier to provider the physician with a form which lists those elements, but has no answers entered by the supplier

10. ADMC claims are being denied because an order with all 7 elements was not received prior to the therapist evaluation.

The Jurisdiction B DME MAC did not review ADMC requests prior to March 1, 2008; therefore this is an assumptive answer. If the therapist evaluation mentioned was one performed by the supplier in order to determine the appropriate wheelchair need, this can not be accepted until the seven-element order for a wheelchair has been received.

11. We have been receiving denials for our ADMC request stating the doctors initial order cannot be dated the same day as the PT/OT evaluation. The physician order is being written the same day as the evaluation with rehab. The doctor is seeing the patient during the evaluation and signs everything when he is there. According to Medicare policy, the date the doctor signs the PT/OT evaluation becomes the new face-to-face date. In this situation, how can the doctor sign the order with one of the required elements being the face-to-face date, before this time? The Medical Director for TriCenturion, Program Safeguard Contractor for Jurisdiction A and B, stated that this was acceptable to have everything dated same date but ADMC continues to deny for this reason.

The Jurisdiction B DME MAC was not responsible for the review of ADMC requests prior to March 1, 2008; therefore this is an assumptive answer. If the treating physician saw the patient for a mobility examination and with the assistance of a PT/OT completed the face-to-face examination as well as signed off on the PT/OT portion all in the same day, it is possible to have a seven-element order dated the same date. This is not typical and would rarely happen.

12. We are instructed by Medicare that if a patient received a Power Wheelchair within the 5 year period that we should bill with an RP modifier on the chair. We bill this way but will still be denied for same or similar and forced to go through

the appeal process. We also have approved Advance Determination of Medicare Coverage (ADMC) on file as well. Is there anyway to avoid this denial?

The Advance Determination of Medicare Coverage (ADMC) process requires the "reviewer" to base their determination for coverage solely off the documentation submitted with the request and the coverage criteria outlined in the Local Coverage Determination and Policy Article. Suppliers must be mindful that an affirmative determination does not guarantee reimbursement. The Medicare Processing System is programmed to validate Medicare requirements (e.g., place of service, Medicare Secondary Payer, same or similar, patient status) prior to allowing the claim to finalize into a payable status. For complete instructions and additional details regarding the ADMC process, please consult the Jurisdiction B DME MAC Supplier Manual, chapter 8 ***Advance Determination of Medicare Coverage*** **located on the National Government Service Web site at www.NGSMedicare.com click on AdminaStar Federal, Jurisdiction B DME MAC and Manual.**

13. I have had a few power chair and scooter claims that were sent to Redeterminations. With each of these, the Medicare Appeal Decision was unfavorable, but the explanation given in the letter from CMS did not adequately explain the reason for the unfavorable decision. In each instance the following paragraph was included as the reason for the decision:

"The documentation submitted does not show PATIENT meets criteria letter(s) documentations supporting the need for this item. Therefore the POV (or PWC) is not allowed. Please refer to the local coverage determination for Power Mobility Devices effective November 15, 2006 for complete guidelines."

As you can see, this does not supply any useful information as to the reason for the denial.

I called Customer Care Department about one of these claims. The Customer Care Representative agreed with me and sent the claim to a Provider Relations Research Specialist for review. As a result, I received a letter stating that they also agreed that the decision was not specific. I then received a revised Medicare Appeal Decision. This letter included the following explanation:

"The documentation submitted does not establish the medical necessity for the power wheelchair because documentations provided do not support the medical

necessity for this item. Therefore, the power wheelchair and related accessories are not allowed."

I believe that I have met medical necessity for this equipment. As you know, medical necessity is complex for these items. I am currently left to guess as to what additional documentation is required. I want to know if there is a way to have someone call me (preferably the person who made the decision) who can explain which portion of medical necessity has not been met. Only then will I be able to correct any missing documentation issues.

Document Control Numbers were requested and received for the redetermination decisions that were in question. The Redetermination Department reopened these appeal requests, so that additional clarification could be provided as to why the claims were denied.

Ostomy/Urological/Medical Supplies
No questions submitted.

Diabetic Monitoring and Supplies
No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

14. Has there been any considerations given to the development of a modifier to indicate we are billing for denial only in order for secondary coverage to be utilized?

    The Medicare Program does not make provisions for suppliers to bill for a denial solely for the purpose of allowing a secondary insurance to pay. Claims submitted to the Medicare Program must be coded according to the instructions outlined in the Local Coverage Determinations and Policy Articles. In cases where the patient does not meet the coverage criteria for a particular item or service being provided, suppliers are reminded of their right to execute an ABN and code the claim with the GA modifier. In cases where the services are excluded from coverage, suppliers must code the claim under the assigned HCPCS and append the appropriate modifiers (GZ or EY) if applicable.

15. Will Medicare reimburse for accessories on patient owned equipment, if the equipment was purchased by another insurance company prior to becoming eligible for Medicare? What documentation is required to bill accessories on patient owned equipment?

Medicare will reimburse for accessories used with patient owned DME, as long as the patient meets the coverage criteria for the DME the accessories are being used with. Suppliers must refer to the appropriate Local Coverage Determination and Policy Article to ensure that the patient meets the coverage criteria indicated and the documentation guidelines are met. The Local Coverage Determination and Policy Articles for Jurisdiction B DME MAC can be viewed at: www.NGSMedicare.com click on AdminaStar Federal, Jurisdiction B DME MAC and then Medical Policy.

16. We have recently received CO-16 denials for all claims that were billed after January 1, 2008 where the place of service was 13 assisted living. We have gone through level one of Customer Care and then worked with a tier two representative on this issue. We were told that a memo has gone out to all staff members at Jurisdiction B that this was a processing issue. We were told that it is a Medicare computer and that the programmers are working on the issue. We were told that the issue should be corrected by the end of February and that a final decision has not been made yet as to whether Medicare will reprocess all of the claims or if it will be the suppliers responsibility to resubmit the claims. What is the current status of this issue and when will providers be notified of the system error Medicare is experiencing?

    National Government Services has identified a system error causing claims submitted with place of service 13 to deny CO-16 in error. National Government Services is currently working to resolve the error and will notify the supplier community of the resolution as soon as it is complete.