National Government Services

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Medicare

Jurisdiction B Durable Medical Equipment
Medicare Administrative Contractor (DME MAC)
Council A-Team Questions
July 31, 2008
Sorted by A-Team

Home Medical Equipment

1. Will National Government Services update the Additional Documentation Request (ADR) letter for Lymphedema pumps to reflect the current coverage criteria listed in the Local Coverage Determination (LCD) for Pneumatic Compression Devices?

   Yes, upon review of the existing ADR letter for Pneumatic Compression Devices, National Government Services determined that the ADR letter is out dated and has taken steps to get it corrected.

2. We are receiving CO-16 denials (Claim/service lacks information which is needed for adjudication) for the wheelchair lap trays E0950. We bill these with the wheelchair. When we request a Redetermination and show that it is being used with the wheelchair, it is then paid. How should this be billed initially so that we can avoid the denial and having to submit a redetermination request?

   Claims for a wheelchair lap tray must be coded as E0950 followed by the applicable pricing modifier NU, RR or UE. In addition, when billing for accessories for patient-owned equipment suppliers are required to indicate in the NTE Segment of their electronic claim or box 19 of the CMS-1500 Claim Form that the accessories are being used with patient-owned equipment and the make and manufacture/model number of the equipment. Suppliers are reminded that Medicare patients must meet the coverage criteria for the base equipment that the accessory is being applied to as indicated in the documentation requirements section of the local coverage determination. Depending upon the base of the wheelchair the KX modifier may be required. For additional information regarding the LCD for Wheelchair Options and Accessories, please visit the National Government Services Web site at: www.NGSMedicare.com and click on the *Coverage* menu item.

3. We have a patient that was prescribed a manual wheelchair (K0001) for 2 months due to a fractured ankle. The podiatrist who performed the surgery also prescribed the wheelchair.

CMS
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Per the Jurisdiction B Council Q&A document dated 2/6/07 question #2c states that a podiatrist cannot prescribe a wheelchair. Please provide clarification for this requirement. If a podiatrist is prohibited from prescribing a wheelchair, what information should be indicated on the Advance Beneficiary Notice (ABN) so that the supplier can bill the patient?

A podiatrist can prescribe a manual wheelchair but cannot prescribe a power wheelchair or power operated vehicle, barring any state licensing law to the contrary. An ABN would not be required in the scenario indicated above.

4. Medicare normally estimates that medical equipment has a useful lifespan of 5 years.

   (a) If the patient equipment is able to be repaired, and the patient has had the equipment for 5 years, what criteria does Medicare want us to use to decide if the patient should get replacement equipment or we should repair patient-owned equipment? At what dollar amount, does Medicare figure that a piece of equipment should be replaced, rather than repaired, even when repair is an option?

   The Medicare guidelines for the replacement of durable medical equipment state that the reasonable useful lifetime requirements are determined by the contractor, but in no case, can it be less than five years. Medicare only allows for replacement of an item prior to the reasonable useful lifetime of five years if the original equipment has been lost, stolen, irreparably damaged, or the patient's medical condition changes (i.e. if the equipment that was originally provided no longer meets the patient's medical needs).

   Note: All DMEPOS items do not fall under the 5 year rule. Suppliers are encouraged to review the Local Coverage Determinations for the DMEPOS items being replaced to verify the reasonable useful lifetime.

   If the beneficiary has had the item for more than 5 years, the decision to repair or replace the item is left to the judgment of the supplier and beneficiary. If the item continues to meet the patient's medical needs, is still in reasonably good condition, and the cost of repair is relatively low compared to the cost of replacement, then repair would be appropriate. In other situations, replacement of the item may be appropriate. It would certainly be appropriate if the cost of repair were greater than the cost of replacement. If the item is being replaced, the reason for the replacement should be documented in the supplier's records.

   (b) If we know that the equipment was purchased by Medicare, is it safe to assume that Medicare will cover repairs on the equipment?

Suppliers are encouraged to pre-screen their patients and secure as much medical documentation as possible to support the need for patient owned equipment being repaired. It is not recommended to assume that just because Medicare paid for the equipment, the repairs to that equipment will be covered. Pre-screening patients to ensure that the medical necessity for the equipment still exist and that additional equipment was not obtained or in use after the purchase date of the equipment being repaired may reduce the possibility of your claim being denied for medical necessity or same/similar equipment already in use.

(c) Where can suppliers find information in writing on what needs to be documented?

The Centers for Medicare and Medicaid Services (CMS) instruction on repair and replacement items are located in the Internet Only Manuals, Publication 100-04 Medicare Claims Processing Manual, Chapter 20, Section 10.2 ***Coverage Tables for DME Claims,*** **and Section 50** ***Payment for Replacement Equipment*** **and Publication 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.2** ***Repairs, Maintenance, Replacement and Delivery*****. To access these manuals, please visit the CMS Web site at www.cms.hhs.gov and click on the Regulations and Guidance menu option.**

5. Will Medicare cover a transfer board (E0705) if the beneficiary is not using it with a wheelchair? For example, the beneficiary requires the use of a transfer board to transfer from a bed to a commode.

   Yes, Medicare will cover a transfer board when it is deemed medically appropriate and necessary for the Medicare beneficiary to make transfers to and from durable medical equipment.

6. Negative Pressure Wound Therapy (NPWT) supplies, specifically the wound care kits, appear to have remarks on the packaging that would indicate the kit should not be stored in temperatures below 77 degrees, and should not get wet. Given these warnings, the HME supplier cannot take back unused supplies since we cannot be certain how they were stored once outside our control. Therefore, can the HME supplier bill for wastage of these supplies? Consider the following: the physician orders dressing changes of 2x per week, or 8 kits x month. The patient gives up the equipment before the month's billing is over and the patient has 4 unused kits leftover. If we cannot return the supplies to usable inventory, can we bill and receive payment for the quantity the physician ordered? Likewise, if the physician orders the large kits and the patient really needs the small ones, if the kits have been out of the supplier's direct control, we would not be able to return them to usable inventory.

Suppliers must bill for the total units of service provided on the dates of delivery. In the first scenario provided above, the physician ordered 8 kits per month. Prior to the month's end, the physician changed the plan of care and the equipment was returned to the supplier. In this scenario, the supplier would still bill for the 8 kits provided and use the date of delivery as their date of service. The supplier would not be obligated to accept the unused kits and or refund any payments previously made to the Medicare Program.

With respect to the second scenario indicated above, suppliers are required to secure wound characteristics from the ordering physician when the initial order is placed; therefore the supplier should be able to assess what the appropriate dressing size should be. If the physician ordered the incorrect size, the supplier should get a new order for the appropriate size dressing. If the inappropriate size was delivered and billed, those would be considered not medically necessary. If the supplier receives payment, a voluntary refund should be initiated.

7. Can a patient be on a Group III support surface and receive Negative Pressure Wound Therapy (NPWT) at the same time?

   If a patient qualifies for a Group III Support Surface for pressure reduction and NPWT to promote healing (coverage is typically limited to 3 months) they should not be considered "same or similar" equipment. There is no indication in either policy that these cannot be used simultaneously, as applicable, on an individual case basis if medically necessary.

8. What is the definition of "supervise or directly perform the NPWT dressing changes on a regular basis" (continued coverage requirement)? Does this mean that the licensed health care professional him/herself must perform every dressing change, or does this mean that a family member can perform a dressing change with supervision from the licensed health care professional? This question comes up because the physician prescribes 12 dressing kits per wound per month (3 dressings x week), but the home health agency visits are prescribed 2 x week. Since the HME supplier cannot control how often the home health agency is directly performing dressing changes, we wonder how "supervision" is defined. Can this be consultation between the caregiver and licensed health care supplier over the phone, periodic Q&A during scheduled visits, etc. or must it be direct, "over the shoulder" supervision?

   A licensed health care professional should be directly performing the NPWT dressing changes in most situations. This is particularly important during the early weeks of

treatment. After a number of weeks, if the patient's wound is healing without complications, it would be acceptable for the clinician to instruct the patient or caregiver in how to perform the dressing changes. There should be documentation of the instruction in the medical record. Even at that point, the expectation is that the health care professional would be seeing the patient and observing the wound at least weekly.

9. The local coverage determination (LCD) notes that the practitioner "should" be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT. Is an HME supplier expected to verify or validate such credentials with each practitioner that a home health agency sends out?

   The LCD is very specific on the types of licenses that are appropriate for the licensed health care professional such as physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). It is expected that due to varying state laws the licensed health care professional is working within the scope of their practice according to their state laws. The supplier supplying these DME items must be aware of these laws and should know if these specified licensed professionals are able to perform these dressing changes.

10. Most of the Negative Pressure Wound Therapy (NPWT) policy discusses a "licensed health care professional", except in the area discussing the KX modifier. The LCD says the medical record must include a "statement from the treating physician describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care listed in criteria A1-A4". Does this mean that documentation of these points from a licensed health care professional (as it is otherwise defined in the LCD) is not acceptable to initiate the NPWT process? It appears to read as though a physician must initiate the need for NPWT and must have documented this in his/her records, qualifying the patient initially. From there, a licensed health care professional can perform the dressings, supply the additional documentation or continued coverage documentation criteria.

    As stated in the Indications and Limitations of Coverage section of the LCD for Negative Pressure Wound Therapy, a licensed medical professional may document the "evaluation, care, and wound measurements". This person may have no financial relationship with the supplier. If the ordering physician has been actively involved in the management of the wound and if the physician reviews, revises as needed, and signs the document prepared by the licensed medical professional, the document would comply with the statement in the Documentation Requirements section of the LCD.

Enteral/Parenteral/IV Therapy

11. We have a question regarding enteral formula orders in which we do not have enough of the patients formula to provide a full months supply. For example a patient requires 5 cases per month, we have only 3 cases in stock and 2 are on back order. Should supplier bill the three cases with a date span indicating that it is only for a partial month and then submit a separate bill once the patient gets the remaining two cases, or are we to hold the bill until the patient receives the remaining two cases and send in just one bill? If we are to hold the bill until patient receives the full order do we use the date we sent the first cases or do we use the date the patient received the remaining cases?

    In cases where enteral nutrition must be delivered in two separate shipments due to a back order, supplier should submit a claim to Medicare for the portion of the services rendered in the first shipment. The service dates for the first shipment should be spanned to cover the dates of service shipped. Subsequent claims for the remaining shipment should be submitted and the dates of service should be spanned to cover the remaining days in the supply. Suppliers are reminded that enteral nutrition must be date spanned and the calories per day must correspond with the units billed monthly. Enteral formulas B4149–B4150, B4152–B4155 and B4157–B4162 all list that 100 calories is equal to 1 unit.

Respiratory Care Equipment/Oxygen Therapy

12. When a patient qualifies for portable oxygen and they have been provided with a portable system but have not been getting any oxygen refills for quite some time, can we leave the portable system in the patient's home? The patient still needs the portable oxygen to go to physician appointments, etc. and still qualifies for portable oxygen due to desaturation during activity.

    Medicare will only cover items that are being used by the beneficiary. For portable oxygen, the need and use may be intermittent. However, if a patient has not used portable oxygen for two consecutive months, Medicare coverage would end.

13. We are receiving PR-96 denials for trach masks (A7525). When we send the denials to redetermination and show the equipment it is being used with, it is then paid. How should this be billed initially so that we can avoid the denial and having to submit a redetermination request?

    Upon review of the claim examples provided, the Jurisdiction B DME MAC determined that processing guidelines for A7525 needed to be updated. However, suppliers are reminded that the LCD for Nebulizers lists the usual maximum frequency of

replacement of a trach mask (A7525) as one per month. Claims for more than the usual maximum replacement amount must be supported by documentation in the patient's medical record, which must be available upon request.

14. Regarding oxygen converting to purchase after 36 months:
    a. If a patient is set up with a compressed oxygen system and then the physician orders liquid oxygen or the patient wants to switch after several months are we required to switch them? If so, can we charge for an upgrade?
    b. If a patient has a concentrator for their stationary unit and liquid for portable do both the reservoir and portable convert to purchase or does the reservoir remain ours and we pick up when no longer needed?
    c. If the reservoir does not convert to purchase as part of the portable system and the pt wants us to make travel arrangements can I charge the pt the cost incurred other that the liquid contents which I would be billing to MCR? (in the past as part of ongoing service we would have provided them with appropriate equipment to travel of worked with another homecare company)
    d. Has any information been released on how they plan to compensate suppliers for portable oxygen once the cap is implemented? If reimbursement remains the same suppliers will not be able to afford to send the number of tanks required for high liter flow patients. What are they proposing?
    e. If a patient owned concentrator quits working due to normal wear and tear but the machine is deemed not repairable, will the patient be responsible for purchasing a new concentrator if owned less than 5 years?
    f. If a patient moves to another state and has a MCR purchased concentrator will a supplier be compensated for assuming the O2 therapy and providing O2 supplies (cannulas, after hours calls)
    g. Once the oxygen equipment is capped, will an oxygen CMN be required for the O2 contents, cannulas, tubing, etc?

    The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. Under the new law, the payment policy for home oxygen therapy has changed. CMS is moving quickly to implement the new law and will soon issue contractor instructions and issue accompanying Medicare Learning Network (MLN) Matters articles with more information. Once the contractor instructions have been issued, the Jurisdiction B DME MAC will provide a response to this question and all of its subparts at that time.

15. In regard to Brovana/Perforomist:

a. What constitutes "Routine" use of a short acting beta agonist (SABA)? A patient or physician will know rather quickly if a medication is not bringing relief. If the "routine" use of a SABA was a day, for example, does this meet the criteria?

See examples 1 and 2.

"Routine use" of a SABA would generally be two months or more. Long acting beta agonists (LABAs) such as Brovana or Perforomist have a mechanism of action that is identical to SABAs. They don't "bring relief" to patients who don't respond to SABAs. The advantage of LABAs is that they can be given less frequently. When using beta agonist drugs, it is appropriate to start with SABAs and determine how often the patient needs to take the medication to control his/her symptoms on a chronic basis. If a patient is not consistently taking at least the FDA-recommended maximum daily dose of SABAs (i.e., 4 doses per day of Albuterol or 3 doses per day of Levalbuterol), then it would be appropriate for the patient to remain on SABAs. If the patient is consistently requiring the FDA-recommended maximum daily dose of SABAs to control symptoms, then the physician may consider switching the patient to a LABA. Because the symptoms of COPD may fluctuate, it is reasonable for the patient to remain on SABAs for at least a couple months before considering a switch to an LABA.

b. Is a letter of medical necessity, notes on a prescription pad and check box on a form insufficient documentation? See example 3 below.

No, those are not acceptable substitutes for contemporaneous notes in the patient's medical record.

c. Is there a point where the gap between the SABA usage and the LABA prescription are too great? See example 4 below.

Regular use of SABAs should immediately precede the use of LABAs.

Pt #1: Doctor provided us an email from the patient's chart where he directed the patient via the email to obtain Albuterol and Atrovent from American Home Patient for QID use. We have no other "chart" notes available to us. We have no proof the patient executed this physician's instructions. In regard to the email situation, we have observed more physicians communicating in this way in recent years. With some policies emphasizing the need for patient medical records and chart notes, are emails between patient and physician considered an adequate means of documentation, or would we expect that the physician must duplicate this conversation within the patient's chart?

If a physician sends an email to the patient and includes a printout of that email in the patient's chart, that could be considered part of the patient's medical record.

Pt #2: Our pharmacy has an prescription for Xopenex Q4h (6xday). The patient's actual usage was only two fills of Xopenex (72 doses each) in a 12-month period. Clearly the patient did not comply with the frequency of the physician's order. Xopenex use is required at TID usage (3xday) prior to establishing the need for Brovana. In this case we declined the order, going by the usage we observed rather than the prescription that was written, but in other cases, we could routinely be getting notes from the physician about what was prescribed without really knowing what the *usage* was if we were not the filling pharmacy.

It is correct to utilize information about a patient's actual usage of a drug rather than the physician's order to determine whether the patient was routinely using the FDA-recommended maximum daily dosage. Patients often need/use less of an inhalation drug than is ordered by the physician. That is the reason why the Nebulizers policy states: "The pharmacist is responsible for assessing how much inhalation solution a patient is actually using."

Pt #3: Physician misunderstands the use of PHI/HIPAA rules. He refused to provide us with the patient's records citing other non-applicable treatments weren't our business and couldn't be isolated. He wrote a short letter of medical necessity instead of providing the chart note, stating the patient had tried QID usage of a SABA. We could not convince him otherwise. Lacking other evidence of usage, we turned this patient away. Could we have used an LMN or prescription pad statement about trial/usage of a SABA?

The standard for documentation is contemporaneous notes in the patient's medical records. Subsequent prescription pad statements or "letters of medical necessity" are not acceptable substitutes.

Pt #4: Patient had Xopenex TID a few years back. We have no more current information on this patient and their respiratory treatments between then and now. Can the supplier provide Brovana with the only known history on hand? Since there is no discussion of how the "history" is defined, that is the reason for this question.

Coverage of LABAs would require the routine use of Levalbuterol at least 3 times per day or Albuterol at least 4 times per day on a regular basis for at least 2 months immediately preceding the use of LABAs.

16. Please provide clarification for Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RAD) devices and the documentation requirements after 90 days. We get the beneficiary letter completed and signed and the patient indicates over 4 hours per night use. However, there are times when we also obtain a download and that documentation contradicts the beneficiary statement. We sought clarification from the Clinical Education Department and was told by them that the beneficiary letter is the documentation we use for the KX. However, after the recent Lunch and Learn the Q & A states that if the download indicates less usage than 4 hours per night this is the documentation we use and we cannot use the KX modifier. Which is correct?

    The Medicare Beneficiary Statement and the signed and dated treating physician attestation must be provided for the RAD no sooner than 61 days after initiating use of the device. However, if the beneficiary attests they are using the bipap device and after obtaining a download it is found that the beneficiary in fact is not compliantly using the device, then the supplier should not add a KX modifier to claims for the fourth and subsequent months

17. There are many interface packages available for Continuous Positive Airway Pressure (CPAP) unit. Many include mask A7034, headgear A7035, cushions A7032 or nasal pillows A7033. These packages are dispensed at the initial setup of the CPAP unit. Are suppliers allowed to separately bill for the A7032 or A7033 at the time of the initial set up?

    Per the Local Coverage Determination (LCD) for CPAP, accessories used with an E0601 device are covered when the coverage criteria for the device are met. If the coverage criteria are not met, the accessories will be denied as not medically necessary. The fee schedule allowance for the monthly rental of the CPAP device does not include reimbursement for interface cushions or nasal pillows. Medicare would not cover two different types of interfaces at the same time. However, if one type of interface does not work well for the patient, it would be appropriate to switch to a different type of interface.

Prosthetics/Orthotics

No Questions Submitted

Rehab Equipment

18. The DME MACs recently published the following:

    Wheelchair Options and Accessories – Remote Joysticks and Controllers – FAQ

    Q. What is the correct coding when a standard proportional remote joystick is provided at the time of initial issue of a power wheelchair?

A. There is no separate billing for a standard proportional remote joystick when it is provided at the time of initial issue of a power wheelchair. Payment is included in the allowance for the power wheelchair base. If a nonexpandable controller is provided at the time of initial issue, payment is also included in the allowance for the wheelchair base and there is no separate billing.

If an expandable controller is provided at the time of initial issue, code E2377 (expandable controller) and E2313 (harness for upgrade to expandable controller) are separately billable and payable. If a power seating system is provided and if the system is controlled through the drive control interface, code E2310 or E2311 is used. There is no additional separate billing using code E2399 or K0108 for any components of a nonexpandable or an expandable controller.

These instructions are different than those given in Change Request 5537 and MLN Matters MM5537 dated March 09, 2007 (referenced below) for billing proportional joysticks (drive control interface) and expandable controllers.

According to Change Request 5537 and MLN Matters MM5537 the fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. The upgraded proportional remote joystick provided at initial issue for dates of service on or after January 1, 2007, is separately billable and payable as code E2399.

When an expandable controller is provided at the time of initial issue there are three components that make up a complete system:

1. Expandable Controller (code E2377)
2. Harness for Upgrade to Expandable Controller (code E2313)
3. Upgraded Proportional Remote Joystick Drive Control Interface (code E2399)

If a power seating system is provided and the system is controlled through the drive control interface a 4th component is required,

4. Electronic Connection between Wheelchair Controller and One Power Seating System Motor (code E2310) or, Electronic Connection between Wheelchair Controller and Two or More Power Seating System Motors (code E2311)

According to your answer provided in the FAQ to what the correct coding is when an expandable controller is provided at the time of initial issue of a power wheelchair, codes

E2377, E2313 are separately billable and payable and there is no additional separate billing for an E2399.

The instructions given in CR 5537 applied to claims with dates of service in 2007. In 2008, a new code (E2313) was established to use for the additional electronics for an expandable controller that were billed using code E2399 in 2007.

Please clarify the following:

a. What components does Medicare recognize as billable and payable when providing an expandable controller, upgraded proportional remote joystick and harness on initial issue?

   Medicare recognizes the harness for upgrade expandable controller, including all fasteners, connectors and mounting hardware defined by HCPCS code E2313 and the expandable controller including all related electronics and mounting hardware, upgrade provided at initial use, defined by HCPCS code E2377 as billable and payable when providing an expandable controller upgraded proportional remote joystick and harness on initial issue.

b. What components does Medicare recognize as billable and payable when providing an expandable controller, upgraded proportional remote joystick, harness and one power seating system motor on initial issue?

   Medicare recognizes HCPCS E2313, E2377 and E2310 (if the power seating system is operated using the drive control interface) as billable and payable when providing an expandable controller, upgraded proportional remote joystick, harness and one power seating system motor on initial issue.

c. What components does Medicare recognize as billable and payable when providing an expandable controller, upgraded proportional remote joystick, harness and two or more power seating system motors on initial issue?

   Medicare recognizes HCPCS E2313, E2377 and E2311 (if the power seating system is operated using the drive control interface) as billable and payable when providing an expandable controller, upgraded proportional remote joystick harness and two or more power seating system motors on initial issue.

d. Is the upgraded proportional remote joystick (Drive Control Interface) billable and payable when provided on initial issue with an expandable controller as indicate in Change Request 5537 and MLN Matters MM5537?

Yes, the upgraded proportional remote joystick is billable and payable when provided on initial issue with an expandable controller. For claims with dates of services in 2007, code E2399 is used. For claims with dates of service in 2008, code E2313 is used.

e. If the upgraded proportional remote joystick (Drive Control Interface) is not billable and payable when provided on initial issue with an expandable controller, why?

Not applicable

f. Why is the Frequently Asked Questions (FAQ) answer at a variance with Change Request 5537 and MLN Matters MM5537? Does the FAQ answer supersede Change Request 5537 and MLN Matters MM5537?

The FAQ supersedes CR 5537 for claims with dates of service in 2008

19. If a beneficiary is in a Home Health Episode working with a PT/OT who has orders to evaluate and treat, and the therapist identifies that the patient would benefit from mobility assistive equipment such as a power wheelchair, is it permissible for the ATS to be involved with the mobility evaluation and equipment selection process at this point in the face-to-face process if the ATS is contacted by the therapist?

The PT/OT may assist with the face-to-face evaluation but the patient must be seen by the treating physician. The ATS may not assist with the face-to-face evaluation and begin wheelchair selection. The PT/OT assisting with the face-to-face is not to have any financial relationship with the supplier. Once the Seven Element (written) order and report of the face-to-face examination is received then the ATS may begin their evaluation regarding the appropriate equipment selection.

20. If a beneficiary contacts the supplier for mobility assistive equipment such as a power wheelchair it is permissible for the supplier to provide the beneficiary with a list of therapists and/or clinics in the area that perform seating and wheeled mobility evaluations and request that the beneficiary contact their physician for a referral. If the ATS is involved in the evaluation and equipment selection process with the therapist, regardless of the location of the evaluation, is this an appropriate point in the face-to-face process for ATS involvement?

The supplier in this circumstance should encourage the beneficiary to contact their treating physician for a mobility examination. The treating physician can then determine whether he/she would complete the entire face-to-face examination or refer the beneficiary to an OT/PT for assistance with the exam or for a specialty examination. The supplier should not be involved until the Seven Element (written) order and report of the face-to-face examination have been received.

Ostomy/Urological/Medical Supplies

21. Recent reports are indicating that Medicare will no longer reimburse for hospital acquired pressure sores. We are questioning whether or not this applies to homecare companies and the dispensing of wound management supplies/surgical dressing prescribed for treating these pressure sores? And if so, is there a way to obtain information letting us know the wounds were hospital acquired?

    There has been no change in the LCD for surgical dressings and wound care related DME. A pressure ulcer which was acquired in a hospital is eligible for coverage of surgical dressings and wound care related DME in the home setting.

Diabetic Monitoring and Supplies

No questions submitted

Documentation/Regulatory/Miscellaneous/Other

22. My question is regarding proof of delivery on items that we, personally deliver. We have a delivery ticket the patient signs and dates at the time of delivery. However in some cases the patient or patient's representative neglect to date the delivery ticket. Is the patient or representative required to date the proof of delivery? The document does a have a delivery date on it.

    The Jurisdiction B DME MAC Supplier Manual, chapter 8 *Documentation* instructs suppliers utilizing delivery method number 1 , which is direct deliver to the beneficiary by the supplier, suggest that the supplier should include the following information on the delivery slip:

    1) The patient's name
    2) The quantity delivered
    3) A detailed description of the item being delivered
    4) The brand name, and
    5) The serial number

In addition to the information listed above, the date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee.

23. We have come across a couple cases in which we are billing for a capped rental item and then we start getting PR4 denials. I have talked to a Medicare representative about these denials and was told that Medicare is looking for the BR, BP or BU modifier because they show payments on file for the same HCPCS with a start date prior to January 1, 2006. Are we obligated to then find out if the patient qualified for a break-in-service and send claims to redetermination if they did or can we just send out a rent to purchase option letter?

    Suppliers are encouraged to pre-screen their Medicare patient during intake to validate whether or not the patient has received same or similar equipment prior to the new equipment being prescribed and provided. In the scenario described above, the supplier must not blindly send a rent-to-purchase option letter to the beneficiary without knowing where the payments fall within the previous capped rental history. Suppliers must work with the beneficiary and utilize the resources available to confirm the previous rental history and determine whether or not a break-in-service or break-in-billing occurred. For assistance in determining whether a break-in-service or a break-in-billing has occurred, please view the *Break-in-Service*/*Break-in*-Billing flow chart located under the Tools and Materials link on the National Government Services Web site at:

    http://www.ngsmedicare.com/ngsmedicare/DMEMAC/EducationandSupport/ToolsandMaterials/IndexToolsandMatDMEMAC.aspx

24. Are Continuous Positive Airway Pressure (CPAP) suppliers required to obtain a copy of the "full" sleep study prior to submitting a claim to Medicare, or is the physician interpretation summary sufficient?

    The LCD for CPAP/PAP policy states that the information must available upon request. Suppliers may use the physician's interpretation summary to qualify the patient for CPAP/PAP coverage. If coverage criteria are met, the KX modifier may be appended to the claim. However upon request, the supplier must have access to the full sleep study.

25. Are Respiratory Assist Devices (RAD) suppliers required to obtain a copy of the "full" sleep study prior to submitting a claim Medicare, or is the physician interpretation summary sufficient?

    The Local Coverage Determination for RAD states that appending the KX modifier to a claim indicates that coverage criteria have been met and the required documentation

has been obtained and entered into the supplier's files. Therefore, RAD suppliers are required to obtain a copy of the full sleep study prior to the submission of a claim for a RAD to the Medicare Program.

26. Other sources have posted on their website a list of "suggested abbreviations" for suppliers to use when entering claim notes in the NTE segment. Will National Government Services recognize and accept this same list?

    The Jurisdiction B DME MAC will recognize most abbreviations indicated in the NTE Segment of an electronic claim. In cases where additional information is needed to process the claim, the Jurisdiction B DME MAC will develop the claim and send an Additional Documentation Request (ADR) letter to the supplier. The supplier will have 30 days from the date on the ADR to respond with the requested documentation. In addition, the Jurisdiction B DME MAC is in the process of developing a suggested abbreviations tool for the NGSMedicare.com Web site.

27. The instructions for secondary NPIs state that if a rendering supplier is unable to obtain a referring provider's NPI, they can use their own NPI in the referring provider NPI field. If the supplier submits their own NPI in place of the referring provider's NPI will a DME claim process and pay or will the claim be denied because there is no valid referring supplier?

    If the referring provider does not furnish an NPI at the time of order, the billing supplier must attempt to obtain that NPI in order to use it on the claim. The billing supplier may use the NPI Registry or may need to contact the referring provider in order to obtain the NPI. If unable to obtain the NPI of the referring provider, the billing supplier shall use its own NPI to identify those secondary providers. As long as a valid NPI is submitted in the referring provider field, the claim will not deny because the referring provider field has the same NPI number as the supplier of service.

28. We receive many orders from resident physicians who do not have NPI numbers. What identifier should the supplier place in NPI field, when submitting a DMEPOS claim?

    A resident physician that prescribes DMEPOS items that are to be billed to the DME MACs must obtain an NPI number. Medical students, intern residents, and fellows are eligible for NPIs. If they do not transmit any health data in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard, they are not "covered" health care providers under HIPAA and are not required by the NPI Final Rule to obtain NPIs. However, if they do transmit any health data in connection with a transaction for which the Secretary of Health and Human

Services has adopted a standard (i.e., ordering DMEPOS items for Medicare beneficiaries), they would be covered health care providers and they must obtain NPIs. As stated in MLN Matters article 5674, "Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries."

29. Seeking clarification on repairs to equipment either purchased before patient has Medicare or purchased by Medicare under old guidelines:

    a. If a patient had equipment purchased for them by private insurance and is now on Medicare and needs repairs. What documentation is required to get repairs approved? For example, power chair or CPAP purchased prior to Medicare now needing repair.

       In the *FAQ Repair and Replacement* published October 2007 by TriCenturion, the program safeguard contractor (PSC), suppliers were instructed that the beneficiary must meet current Medicare reimbursement criteria for their patient-owned equipment in order to be repaired if Medicare did not purchase the item. If it was obtained prior to Medicare coverage or if another payer purchased the equipment, the supplier must obtain the required documentation to verify coverage and to determine if the item is covered by a warranty. To review the *FAQ Repair and Replacement* article in its entirety or any other TriCenturion article or FAQ, please visit the National Government Services Web site at www.NGSMedicare.com and click on Education and Support and then Tools and Materials.

    b. If a patient had a piece of equipment purchased by Medicare under old guidelines, for example power chair, and now needs repairs, what documentation is required (face to face, etc)?

       The Medicare Benefit Policy Manual Chapter 15, §110.2 *Repairs, Maintenance, Replacement and* Delivery states in pertinent parts:

       "Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. However not pay for repair of previously denied equipment or equipment in the frequent and substantial servicing or oxygen equipment payment categories".
       The IOM goes on to state:

       "A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs"

In the example provided above, medical necessity for the patient-owned equipment was established upon approval for payment under the previous Medicare guidelines. Therefore, a new physician's order is not required. If a face-to-face was not required at the time the equipment was initially approved and paid for by Medicare, the face to face exam would not be required for the repair. Suppliers are encouraged to screen their patient to ensure that the medical necessity still exist for the previously purchased equipment and to ensure that the patient has not received additional equipment subsequent to the initial purchase.

c. Very complex involved patient in power mobility for years and years and equipment needs repairs. Has not been on Medicare until now. Due to complex nature of the chair patient cannot go without the chair for any length of time (more than a day or two). What documentation would be required to have repairs of the power chair covered?

There would need to be documentation available in the medical record that indicates that the patient meets the medical necessity criteria for a rehab power wheelchair - i.e., the PWC is needed for mobility in the home, the patient's mobility needs cannot be met by a POV, manual WC, or walker, and the patient's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal abnormality. There would need to be documentation in the supplier's records of the need for repair.

30. When we receive OA-109 denials because a patient is in a skilled nursing facility we are unable to get any provider information from Customer Care on where the patient was during this time. Will Jurisdiction B reconsidering their process for releasing this information?

The Jurisdiction B DME MAC has updated the Customer Care Representative instructions regarding the OA-109 denials to include the release of the provider ID for inpatient episodes (SNF, NF, HHE) upon request. Suppliers are reminded that disclosure requirements must be met in order for the Customer Care Representative to release this information. For additional information regarding the Customer Care Contact Center and the Interactive Voice Response Unit, please visit the National Government Services Web site at:

http://www.ngsmedicare.com/ngsmedicare/DMEMAC/Resources/ContactInformation/Customer%20Care_ContactInfo_DMEMAC.aspx

Or suppliers may consult the Jurisdiction B DME MAC Supplier Manual, chapter 22 *Customer Care* at:

http://www.ngsmedicare.com/ngsmedicare/DMEMAC/EducationandSupport/ToolsandMaterials/SupManual/Chapters.aspx