Jurisdiction B Council A-Team Questions
Sorted by A-Team
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Home Medical Equipment

No questions submitted.

Enteral/Parentral/IV Therapy

1. Is it acceptable for a provider to deliver equipment/drug and supplies to a facility versus the patient's home to allow for initiation of a continuous infusion that will be continued in the home?

   For example: Shipment of drug/supplies delivered to a Cancer Center. The patient met the courier at the center and signed paperwork upon receipt. Patient was hooked up at the center and returned home for the remainder of the 72 hour infusion. The patient returned to the center to be disconnected.

   ANSWER: Injectable drugs administered in a physician's office, whether with or without a pump, must be billed to the local carrier and not the DME MAC. Drugs put into an infusion pump in the physician's office for use in the patient's home must be billed to the DME MAC if the pump is billed to the DME MAC.

2. There are specialty additives not included in a standard TPN formula such as, Famotidine and Levocarnitine. These drugs are never covered by Medicare under the TPN LCD nor the EIP LCD. Is it appropriate to bill these items using the GY modifier or are we required to obtain a properly executed ABN and bill with the GA modifier? The concern is the lack of understanding on behalf of the beneficiary in that these items are added to their "covered" TPN product however, are not payable by Medicare. This question was also presented to Jurisdiction C and this was their response: Both of the additives are considered non-covered (i.e., don't meet the prosthetic benefit) because they're not considered "nutrients" but rather drugs that get added to PEN solutions. So a

GY would be appropriate for those claim lines. Assuming the patient meets the prosthetic benefit, we would cover the PEN solution and the pump. Just because the two noncovered drugs are billed in addition to the pump and PEN solution, that wouldn't make the whole claim noncovered.

ANSWER: This is a billing question. The apparent issues of concern are: should the supplier bill the drugs added to the TPN using A9270, and then with a GY or not? There is no coverage under Medicare for drugs or other additives to parenteral solutions. However, any drugs that are added to the solutions should be billed with their appropriate HCPCS codes, whether in this case S0028, famotidine or J1955, levocarnitine. A9270 should only be used if there is no HCPCS code for the additive. Next, the usage of the GY modifier is not necessary. The drug would be denied as non-covered, with or without the GY modifier.

Respiratory Care Equipment/Oxygen Therapy

3. Oxygen for cluster headaches: Change Request 7235 announced that effective for claims with DOS on or after 1/4/11, Medicare will allow for the coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with Cluster Headaches (CH) when these beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence. The claims for these services must contain ICD-9 code for CH (339.00, 339.01, and 339.02) and HCPCS E1399 and a clinical trial procedure code modifier Q0. CR7235 also stated that currently, there are no clinical trials approved or pending approval for the home use of oxygen for CH.

CMS issues quarterly HCPCS updates. Among the new HCPCS codes that are effective as of 7/1/11 are:

K0741 Portable gaseous oxygen system, rental, includes portable container, regulator, flow meter, humidifier, cannula or mask, and tubing, for cluster headaches

K0742 Portable oxygen contents, gaseous, 1 month's supply = 1 unit, for cluster headaches, for initial month's supply or replace used contents

Our question is - When would we use E1399 and when would we use K0741 and K0742? The Policy Article for Oxygen and Oxygen Equipment states: "When oxygen is supplied as part of a CMS approved clinical trial for cluster headaches, equipment must be coded using E1399 (durable medical equipment, miscellaneous)."

ANSWER: Effective for claims with dates of service on and after January 4, 2011, Medicare will allow for coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with cluster headaches (CH) when beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence. The article (MLN 7235) is very clear on how these claims are to be billed. Claims for these services must contain:

- **The ICD-9-CM diagnosis code for cluster headaches (399.00-399.02)**
- **HCPCS Code E1399**
- **Place of Service 12 (home)**
- **The 8-digit clinical trial number is optional**
- **The Clinical Trial ICD-9-CM diagnosis code of V70.7**
- **The Clinical Trial Code Modifier Q0**

4. PAP: A number of physicians have questioned why the word "obstructive" is required on the clinical evaluation notes for a beneficiary entering Medicare. The physician may only write "sleep apnea" and not "obstructive sleep apnea." Physicians have pointed out that the rest of the documentation we have on the patient does state obstructive sleep apnea, like the original sleep study, the original prescription where the physician first prescribed the PAP and now the new written order following the beneficiary's enrollment in Medicare FFS. It should be evident from all of these that the patient has OSA. Must the current visit notes also indicate obstructive?,

ANSWER: Sleep apnea is a general term, and there are two types of sleep apnea – central and obstructive. Each type of sleep apnea has different coverage criteria. It is important that the medical record documentation clearly represent the type of sleep apnea manifested by the beneficiary for proper coverage.

5. If an AHI or RDI is 14.3 can it be rounded up to 15? If an AHI or RDI is 14.8 can it be rounded up to 15?

ANSWER: We would accept the normal math parameters. Therefore, (.5) or higher would round up and below (.5) could round down to the nearest whole number.

6. The doctor orders HCPC A7034 on January 1 for the patient. On January 19, the patient is not comfortable and unable to tolerate A7034; the patient is switched to HCPC A7030. On February 1, neither CMN is returned from the doctor. Can the two CMN's be merged to create one CMN? In other words: Can the CMN dated January 1 have HCPC A7034 and A7030 checked off for the doctor to sign?

ANSWER: There is no recommendation for a Certificate of Medical Necessity (CMN) in the Positive Airway Pressure Device policy.

7. If a patient has a primary insurance that pays 100% for CPAP and CPAP supplies and MCR part B is secondary, does the patient have to follow the 90-day trial? same situation: does the patient have to have seen their doctor since part B became effective?

ANSWER: Any time a claim is billed to Medicare, whether for primary or secondary reasons, Medicare payment criteria must be met for payment.

8. If a patient has a primary insurance that pays less than 100% for CPAP and CPAP supplies and MCR part B is secondary, does the patient have to follow the 90-day trial? same situation: does the patient have to have seen their doctor since part B became effective?

ANSWER: See the answer to question number 7 above.

9. If a patient was set-up after 11/1/2008 with a different DME company and that DME company did not record a 30-day compliant download OR a face to face evaluation and we have exhausted all of our resources to obtain that information, does the patient have to see their doctor, have another Diagnostic sleep study and go through the 90-day trial to receive CPAP supplies from us? (The machine has been paid in full to the other DME company from MCR.)

ANSWER: Yes. For more information please refer to the Positive Airway Pressure Devices FAQs on the National Government Services Website at: www.NGSMedicare.com under Resources – Tools and Materials – Question and Answer Resources.

10. If a patient was set-up after 11/1/2008 with a different DME company and that DME company went out of business and we are unable to obtain record of a 30-day compliant download OR a face to face evaluation and we have exhausted all of our resources to obtain that information, does the patient have to see their doctor, have another Diagnostic sleep study and go through the 90-day trial to receive CPAP supplies from us? (The machine has been paid in full to the other DME company from MCR.)

ANSWER: See the response to question number 9.

a. In reference to this and the previous question: If we are able to prove compliance TODAY with the most recent 30-day download and most recent doctor evaluation, (not from the ORIGINAL 90-day trial with the other DME company) will that be sufficient?

ANSWER: No. In order for coverage criteria to be met the documentation must show that the patient met compliance prior to the 4th and subsequent month.

11. According to the DME MAC listserv sent 7/1/11 "Reminder: High Liter Flow Oxygen and Oxygen Equipment Payment and Billing Guidelines", providers must append the QF or QG modifier if physician orders/CMN states greater than 4 LPM.

If a physician orders/CMN states greater than 4 LPM, but the patient was not tested on 4 LPM, how do we bill in this situation? The patient meets the policy criteria for oxygen outlined in the LCD.

ANSWER: A response in question 6 on the oxygen CMN is required if question 5 indicates that greater than 4 LPM of oxygen is prescribed and the supplier expects to receive the higher

reimbursement. The physician must enter the result of most recent test taken on 4 LPM. This may be an ABG or Saturation test with the patient in a chronic stable state.

If the physician completing the CMN indicates that greater than 4 LPM of oxygen is required but they fail to provide a response in question 6 of the CMN you should go back to the ordering physician and advise them because they ordered greater than 4 LPM they must complete question 6 on the CMN. If the ordering physician refuses to do so then you should advise them that the patient does not meet Medicare coverage criteria for more than 4 LPM. In this situation the claim should be submitted without the QF or QG appended and the oxygen will be paid at the standard rate. If question 5 indicates that the physician has prescribed greater than 4 LPM of oxygen and question 6 of the CMN supports the medical need for greater than 4 LPM the QF or QG must be appended.

National Government Services will no longer be adding modifiers to oxygen claims that are submitted without the appropriate modifiers as outlined in the medical policy. If we receive a CMN for a prescribed liter flow of greater than 4 LPM and question 6 on the CMN supports the medical need of greater than 4 LPM we expect to see either the QF or QG appended, otherwise the claim will be rejected. A revised listserv article was published Monday, August 22, 2011 which clarified what was previously published.

12. Much has been published about oxygen saturation and blood gas test results over the past months, mainly, that new tests do not need to be performed. However, our question is what if there are more current test results, should those be reported on the CMS 484 as the most current test for a new 60 month rental period?

For example, a patient has been on oxygen rental for 66 months as of today 5/20/11. We had contacted her 6 months ago and she was interested but wanted to think about it and the different equipment options we were offering. She had a physicians visit on 4/1/11 and during the visit the physician performed an oximetry test on room air which does qualify her again. If we set her up on 6/6/11, should we have the physician use the test results from 4/1/11 since they are the most current? And is it a problem that they were performed more than 30 days prior to the completion of the CMN and the new set up? Or, should the doctor use the original results from 66 months ago?

ANSWER: The Oxygen and Oxygen Equipment Local Coverage Determination indicates that repeat blood gas testing is not required when oxygen is being replaced after the 5-year RUL has been met. Physicians should enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment. In the scenario described above, if the patient saw her physician on 4/1/11 and the physician

performed a qualifying oximetry test, then that would be the most recent qualifying test and should be reported on the initial CMN for the replacement equipment.

13. We have SNF patients to whom we provide oxygen/DME, which is initially included in the consolidated billing by the SNF under qualifying Part A stays. Once the Part A benefit paid by Medicare to the SNF is exhausted, we bill Part B. Part B doesn't cover oxygen/DME while a patient is in a SNF, denying claims with group code PR and reason code 58 (PR-58) - "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

Secondary commercial payers are denying these claims, interpreting the verbiage from the Medicare EOBs literally to mean we billed incorrectly to Medicare and need to submit corrected claims.

We are billing oxygen/DME for SNF patients with place of service (POS) 31. The secondary commercial payers, when they're instructing us to submit corrected claims to Medicare, are of the opinion that we need to use a POS other than 31.

The DME MAC Supplier Manual defines POS 31 as "skilled nursing facility" and defines POS 32 as "nursing facility providing skilled services." Since the definition for both makes reference to "skilled" services, we'd like clarification as to how and when they differ. Further, one of the commercial payers, in response to our appeal, stated that the patient resides in the facility as a long-term care resident, "making it [their] home," which implies that POS 12, 13 or 14 would be acceptable, although we find no Medicare documentation to support this. Please clarify what place of service Medicare's POS 31 vs. 32.

ANSWER: Skilled nursing facilities (Place of Service code 31) patient stays are paid by Medicare Part A. Place of service code 32 is for facilities that provide long-term care not covered by Medicare Part A. An article titled, "Reminders on Billing the Appropriate Place of Service Code on Durable Medical Equipment Claims" was published in June and is available on the National Government Services Web site in the Tools and Materials section of the Resources page. This article provides additional information in regards to this question.

14. A patient receives a CPAP device 4 years ago through private insurance. They use for a few years and then stop using the machine. The patient goes Medicare FFS 6/1/11 and sees the physician 6/5/11. The patient tells the physician they are experiencing excessive daytime sleepiness, fatigue, etc… The physician reminds the patient that they still have sleep apnea and they should begin using their machine. The patient needs new supplies. We obtain notes from the physician that the patient should begin therapy again due to OSA. (We have the original sleep study and qualifying information up till when they stopped using the machine.)

Will Medicare cover the supplies? The rule states the following requirements for beneficiaries entering Medicare:

1. Sleep test and

2. Clinical evaluation that states beneficiary has diagnosis of OSA AND the beneficiary continues to use the PAP device.

Would this beneficiary be allowed to get supplies – technically they don't qualify since they "do not continue to use the device" or would they be required to "start over" with a new diagnostic sleep study. There would be no trial period because they are not getting a machine.

ANSWER: Yes, if the beneficiary owned the device before being on Medicare, then claims may be submitted for supplies along with a notation identifying the item and the date that the beneficiary initially started using it, and that it is beneficiary-owned. If these supplies are subject to an audit, the supplier may be called upon to show that the policy criterion of a properly done sleep study which meets the current Medicare criteria was met. If new equipment is desired, Medicare rules apply, and if it is replacement for equipment from outside of Medicare, the supplier can use the "old" sleep study as long as it meets current Medicare criteria. There also must be documentation of a meeting with the ordering physician that shows the beneficiary is using the device properly and is receiving benefit.

15. Same scenario as above but the patient requires a new machine and supplies. Would the patient be required to have a new diagnostic study and trial period?

ANSWER: Again, it is permissible to use the old test if it meets current testing criteria and the beneficiary has a visit to physician, and the medical records document that the beneficiary is using and receiving benefit. Please refer to the Positive Airway Pressure Device medical policy on the National Government Services Web site at www.NGSMedicare.com, located under the medical policy center.

16. I have heard twice lately that a sleep study oximetry would not qualify a patient for oxygen coverage as they are "not in a stable state". If a patient has a sleep test and the AHI is 3.3 with an average oxygen desaturation of 84% for more than 5 minutes would this test qualify the patient? The test is to determine if the patient has OSA, with an AHI of 3.3 they would not. This would be no different than an overnight pulse oximetry study.

ANSWER: Coverage of home oxygen therapy requires that the patient be tested in the "chronic stable state." Chronic stable state is a requirement of the National Coverage Determination (CMS Internet-only Manual, Pub. 100-3, Section 240.2) and is one of the key criteria when determining coverage of home oxygen therapy.

The NCD defines chronic stable state as "…not during a period of an acute illness or an exacerbation of their underlying disease." Based on this NCD definition, all co-existing diseases or conditions that can cause hypoxia must be treated and the patient is in a chronic stable state before oxygen therapy is considered eligible for payment. In the case of OSA, it is required that the OSA be appropriately and sufficiently treated such that the patient is in the chronic stable state before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy. (See passage in the upcoming draft oxygen policy due out soon.)

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17. Where in writing is it stated that a sleep study oximetry would not qualify the patient for oxygen? We have physicians who do order oxygen based on the diagnostic study and if this is the case we need something in writing to share with them.

ANSWER: The current policy states the patient must be in a "*chronic stable state*" which is not the case if the beneficiary is undergoing the sleep study oximetry study.

18. If during the titration portion of the study the patient's OSA is treated with the appropriate PAP/RAD therapy and the saturation levels are still below 88% for at least 5 minutes then the patient should qualify for oxygen based on the results of the test. This patient should be deemed in a chronic stable state as they have not required any hospital stays between the diagnostic and titration portion of the tests. This test result is not the result of a hospital stay (acute illness) and alternative treatments (use of PAP device only) has been considered and rules out.

ANSWER: See the response to question number 16.

Prosthetics/Orthotics

No question submitted.

Rehab Equipment

19. Group 34 batteries have been coded K0108 by SADMERC/PDAC. Published policy stated to bill as K0108 but the claim would be processed and paid at E2363 allowable. The language in the articles from 2007 and 2009 said that the claim would be 'down-coded' to make that payment adjustment. Since LCD downcoding has been eliminated, do Group 34 batteries now need to be billed as E2363 with the GL modifier (in order for the claim line to process and pay correctly)? Or is this not truly a down-coding situation, and should we continue to bill as K0108?

ANSWER: Suppliers should continue to bill under K0108 until the Pricing, Data Analysis, and Coding Contractor has assigned the Group 34 batteries a HCPCS code.

Ostomy/Urological/Medical Supplies

20. Policy states: Suppliers must add a KX modifier to a code only if the order indicates that the patient has permanent urinary incontinence or urinary retention, and if the item is a catheter, an external urinary collection device, or a supply used with one of these items.

Would intermittent catheters A4351 be covered if using once a week to self dilate secondary to urethral stricture from prostate cancer?

ANSWER: No. A urethral stricture is not permanent urinary incontinence or urinary retention.

21. WOUND FILLER, NOT ELSEWHERE CLASSIFIED (A6261–A6262) Information in the narrative field of the claim is required. Are there guidelines/specific documentation requirements of what information needs to be entered into the narrative field of the claim for these products?

ANSWER: The policy states that the claim must include a narrative description of the item (including size of the product provided), the manufacturer, the brand name or number, and information justifying the medical necessity for the item. This information must be entered in the narrative field of the electronic claim or in item 19 of the paper claim. Suppliers should refer to the document titled, "Situations Requiring a Narrative Explanation in Item 19" for additional information which can be located on the National Government Services Web site at www.NGSMedicare.com, select Resources, Tools and Materials, then locate Self-Help Tools.

22. For fillers, that come in a tube or ropes or paste, how does Medicare want the quantity specified? For example A6240/A6241/A6261. Policy states must document: (c) the number/amount to be used at one time (if more than one).

ANSWER: The long narrative description for each HCPCS code indicates how the unit of service (UOS) is to be billed. For example, A6240 hydrocolloid dressing, wound filler, paste, sterile, per ounce.

Diabetic Monitoring and Supplies

No Questions Submitted.

Documentation/Regulatory/Miscellaneous/Other

23. We need more understanding of the CMS "Medically Unlikely Edits (MUE)". Recently we have received C0151/N362 rejections (A4322 &A7526 – irrigation syringes and trach tube cover) because of the quantity billed. Medical policy does not list a specific quantity for these HCPC'S, so we were surprised by this type of rejection. When calling the DMEMAC, the CSR says that even though there is no quantity listed, the rejections are due to an unpublished or confidential policy for MUE. We are told to send documentation to redetermination to support the quantity. Here is the website from CMS: http://www.cms.gov/NationalCorrectCodinited/08_mue.asp.

ANSWER: We are not permitted to publish or provide information regarding the unpublished or confidential MUEs.

24. What options does a provider have when a patient needs a product after being released from hospice or home health covered stay and that organization won't notify Medicare of that stop date until they get paid? We are running into this problem with a couple of different companies that refuse to officially notify Medicare because they are having problems getting paid.

ANSWER: The DME MACs do not have jurisdiction over Home Health or Hospice agency billing practices. However, like DMEPOS suppliers these agencies have 1 calendar year (12 months) from the date of service to submit their claims to Medicare.

25. We understand that information documented on provider created forms is unacceptable and cannot be considered medical records. In a case where the physician's medical record states that he/she is ordering a patient to be tested for oxygen during exercise and the results are documented on a form created by the physician's office, is signed by the physician, and becomes part of the patient's medical record, would these test results be considered for qualifying purposes?

ANSWER: Yes, forms that are created by physicians for their own documentation purposes and are in the medical record may be used as medical record documentation. We caution physicians on the use of such forms because most do not directly refer to the Medicare coverage criteria and are not addressing all of the information necessary for an assessment of Medicare coverage criteria. They often prompt diagnostic conclusions rather than provide the objective findings that would serve to allow coverage as reasonable and necessary.

26. With the recent push by CMS to implement the 2011 Electronic Prescribing (eRx) Incentive Program for physicians, we have been inundated with requests from physicians to receive various prescriptions and CMNs which they are now generating using electronic software. Without asking the thousands of physicians whose patients we provide service to which software vendor they are using, we as a DME provider have no way of knowing whether or not the physician is using a "qualified" vendor.

a. Is it up to the DME provider to ensure that the physician is using a qualified software vendor for the purposes e-prescribing or will the onus be placed on the physician to be responsible for ensuring that his/her orders are in compliance with the eRx standards?

ANSWER: The DME MACs do not have direction regarding the physician's compliance regarding the eRx standards.

b. Several physicians are sending over prescriptions and/or CMNs which look to be completed via a computer, but physically signed by the physician (using some sort of hand held device) which in turn populates into the prescription/CMN. For the most part, all prescriptions that are sent in this fashion meet all requirements of a detailed written order and/or are otherwise compliant with one exception. The signature date is typed by the physician (we are told) as a feature from the electronic software. In most cases, there is no indication to attest that the documents were electronically signed and dated by the physician but our referrals are adamant that the software vendor is a qualified e-prescribing system. We have seen this software in use in several different states and are told that the software vendor is a "qualified" vendor. We are not currently accepting these items and requesting additional documentation in support of the order. However, with the push to eRx we are seeing more and more of these come through and would like to know if the DME MACs will accept an electronically signed (using an electronic signature pad) prescription/CMN where the signature date is populated to look like a typed date that is populated via the software program without an attestation to indicate that the document was "electronically signed and dated by the physician"? SAMPLE AVAILABLE IN SEPARATE FILE

ANSWER: CMS has not provided/published detailed guidance around the parameters of what is an acceptable electronic signature. Suppliers must be prepared to authenticate the signature and date if done electronically in the event of an audit.