Jurisdiction B Council A-Team Questions
Sorted by A-Team
November 17, 2011

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Home Medical Equipment

No questions submitted.

Enteral/Parentral/IV Therapy

1. What is the standard regarding additional medical documentation needed to support specialty nutrients? At this time a resident's diagnosis typically supports specialty nutrients (i.e. Insulin Dependent Diabetes Mellitus (IDDM) for diabetic formulas due to blood sugar fluctuations, etc.) Is additional documentation required to support medical necessity?

   The Enteral Nutrition Local Coverage Determination (LCD) is not diagnosis driven; therefore, diagnoses alone are not sufficient to support medical necessity. It is expected in an audit situation that documentation from the treating physician's notes would justify the need for the item ordered/provided. This documentation must justify why a specialty nutrient is needed based on that unique beneficiary's medical conditions and need for the type of nutrient ordered.

2. Is the parenteral/enteral nutrition (PEN) pump automatically denied if a patient is receiving bolus feedings sporadically during the day? For example, there are some patients that have supporting medical documentation for the pump but intermittently require bolus or gravity feedings during the day. In this scenario would Medicare consider payment of the pump or would Medicare only allow payment for the restrictive method of administration (i.e., bolus, gravity)?

   No, it is not automatically denied; however, the documentation must justify the need for the beneficiary to use a pump. If a patient can tolerate bolus or gravity feedings then a pump would not be medically necessary and would be considered a convenience.

Respiratory Care Equipment/Oxygen Therapy

3. We are finding it difficult to supply the cool humidifier, E0561 to customers who have a script for cool humidity with their positive airway pressure (PAP) device. The majority of humidifiers available today include the option of turning off the heat element so that cool humidity can be provided. Is it appropriate for a supplier to dispense a humidifier that can provide both heated humidity and cool humidity if the treating physician prescribed a PAP device with cool humidity, we would bill the Health Care Common Procedure Coding System (HCPCS) code for the item prescribed (if heated ordered, bill for a E0562 while turning the heat on and if cool ordered bill for a E0561 while turning the heat off, which ever the MD has on the script)?

   An E0561 is for a non-heated humidifier, used with a positive airway pressure device. If the item you are providing meets the product classification list for an E0561 and the physician ordered cool humidity, then this would be acceptable. Correct coding rules preclude using an incorrect code for any device.

Prosthetics/Orthotics

No question submitted.

Rehab Equipment

4. If a beneficiary who needs repairs to a Medicare covered wheelchair (for example, tires - E2211 - are worn and no longer safe, armrest pads - K0019 - are torn and causing skin irritation), do we need a current detailed prescription in order to bill these repair parts (would they be considered replacement parts) to Medicare?

   Suppliers often are unsure about when a prescription is needed for repair of an item versus replacement of an item. Medicare defines replacement to be the situation when the beneficiary receives an entire new item, which in the case of a wheelchair, is the entire or base wheelchair. "Replacement" in this scenario does not refer to the replacement of pieces and parts during a covered repair.

   Tires (and batteries) are replaced like a repair and do not need a prescription. There are other exceptions such as ventilators which fall into the "frequently serviced" payment category. Note that capped rental items which are currently in the rental phase or covered by warranty receive no separate payment for repair or replacement – and for wheel chair bases, tires and batteries are exceptions.

   Therefore, a prescription/order is needed for replacement of the entire item, such as the entire wheelchair base, if it is lost, stolen or irreparably damaged, or has surpassed the five year reasonable useful lifetime (RUL). Armrest pads are eligible for replacement if they are

"broken" due to damage, and cannot be repaired (i.e., new bolts, nuts, fabric, etc.), but a new prescription/order is not required.

Items which may have to replaced, are separately payable, and for which separate medical necessity is established (e.g. elevating legrests) require a new prescription/order when replaced if they are lost, stolen, irreparably damaged or due to RUL. It is useful to think about the possibility of repair or replacement by asking first, what needs to be paid for – a component of an item or a base item? Then, what is the reason it is not useable? If it can be repaired, then no prescription is needed.

5. Please verify whether wheelchair cushions can be replaced due to wear and tear when they are less than five years old. The manufacturers warranty is generally 12-18 months, depending on classification. If a cushion deteriorates so that it no longer provides adequate support or protection, the warranty is expired and the cushion cannot be repaired will Medicare allow for replacement?

   No. DMEPOS, by statute, has a 5 year reasonable useful lifetime, based on continuous use by the beneficiary. Medicare's RUL does not take into account manufacturer warranty lengths.

Ostomy/Urological/Medical Supplies

No Questions Submitted.

Diabetic Monitoring and Supplies

No Questions Submitted.

Documentation/Regulatory/Miscellaneous/Other

6. Please explain what a DMEPOS supplier should do when a Medicare beneficiary comes in and insists on paying cash for the purchase of an item that would normally be a rental item only with Medicare. For example, a patient comes in and wants to purchase out right a wheelchair which Medicare will only allow rental on. If the patient has a script but clearly does not have the medical necessity for a wheelchair but, they still want it and instead of going through the monthly rentals, they only want to pay a one time purchase amount, can they do this?

   Suppliers should inform beneficiaries that in order for Medicare to consider coverage of an item that falls within a capped rental payment category the item must be billed to Medicare on a monthly rental basis. In most cases, after 13 months of rental have been paid, the beneficiary owns the DME item, and after that time Medicare pays for reasonable and necessary maintenance and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of the item.

If the supplier determines that the beneficiary does not meet Medicare coverage criteria for the item prescribed and expects that Medicare is likely to deny the item as not medically necessary, the supplier should inform the beneficiary in writing via the Advance Beneficiary Notice of Non Coverage (ABN). If the beneficiary selects Option 2 on the ABN, the supplier may collect payment for the purchase of the item and would not be required to bill Medicare.

7. If a Medicare beneficiary is a resident in a skilled facility, and needs repairs to a wheelchair purchased for them by Medicare before they entered the facility; we know this repair is non-covered because of the place of service. But does the provider need to obtain an ABN and file a claim?

Medicare does not cover durable medical equipment (i.e., wheelchairs) while a patient resides in a skilled nursing facility, this would extend to repairs of durable medical equipment. If a beneficiary is using their own wheelchair while in a skilled nursing facility and it needs repair, the repairs are not payable by the DME MAC. The supplier would not be required to submit a claim to the DME MAC for the repairs. An ABN would not be appropriate in this scenario.

8. For pre-payment review, reopening, redetermination or reconsideration appeals, what date range of information, specifically physician orders, physician, speech therapy, or dietary notes, need to be submitted to support coverage. Are there different date ranges acceptable for different types of medical documentation? Can guidelines be published so that suppliers can periodically collect updated supporting documentation? Currently there is no requirement for a supplier to routinely update its documentation other than to gather documentation when enrolling or when patient need changes.

Progress notes, test results or evaluations by other healthcare providers should be within a reasonable timeframe, relative to the date of service in question. This is to ensure that the patient's medical condition is appropriately treated and has not changed between the time of the test or evaluation and the provision of DMEPOS or other therapy.