Region B Council Frequently Asked Questions
June 24, 2004

Home Medical Equipment

1. Per Q&A, May 30, 2002, Question #65, a reviewable B17 denial is one that has 107 denials associated with the B17 denial. We have had several B17/107 denials that were sent to review which are forwarded directly to claims processing without ever being logged as a review. As a result, we have had claims for cushions that were denied as 96 M124 re-denied as duplicates because the review that they were submitted on was never processed, and as a result are past timely filing to send to review again. We have spoken to several CSR's and they tell us that they have no review on file. We have been told by CSR's and supervisors that B17 denials are not reviewable. Please clarify. We have examples to provide upon request.

   Examples requested from supplier. This issue is being worked individually with the supplier.

2. Per the Medicare policy clarification on power wheelchairs "the patient's medical record consists of SOME OR ALL OF THE FOLLOWING: physician notes, nonphysician clinician notes, nonphysician clinician evaluations." I have submitted several power wheelchair ADMC requests to Medicare that all included a signed CMN and a physical therapist's evaluation." The therapist on all cases was referred by the treating physician and was not paid by the supplier. My requests were denied stating that there was nothing to indicate that the information I sent was part of the beneficiary's medical record. Per the policy, some or all can be provided and an evaluation was included that meets the correct criteria. The policy should state "all of the following" if that is what is needed. Is there any clarification that can be given on this? What is acceptable proof that the treating physician referred the therapist?

   The Region B DMERC continues to follow the documentation guidelines for power wheelchairs which were published in the December 2003 Region B DMERC Bulletin article. That article said that one of the acceptable primary sources for medical records is: Nonphysician clinician (e.g., physical therapist or occupational therapist) evaluations that meet all of the following criteria:

   a) Performed on referral from the treating physician; and,
   b) Performed "in person" and not conducted by telephone; and
   c) Performed by a Medicare provider or employee of a Medicare provider; and,
   d) Clinicians are not employees of or otherwise paid by the wheelchair supplier.

   If the supplier is submitting a report from a PT or OT that it wants the DMERC to consider as primary source documentation, then they should include a statement signed and dated by a responsible person from the supplier's office providing the following information: 1) Medicare Provider Name, Provider Number, and State of the entity that will be billing Medicare Part B for the evaluation, and 2) a statement indicating whether or not the Part B provider or the individual therapist has been or will be paid in any way by the supplier for performing the evaluation. If the attestation and evaluation verify that the criteria above have been met, then additional physician records will not be needed. If the attestation is not included with the ADMC request or claim, the DMERC will consider the PT/OT evaluation as secondary source information and will require copies of physician progress notes to verify that power wheelchair coverage criteria have been met.

3. Does the Advance Determination Policy apply only to Tilt-In-Space or to all Manual Adult size wheelchairs as the current policy implies?

   The following codes are eligible for ADMC: E1161, E1231 – E1234, K0005, K0009, K0011, and K0014. This information can also be found in Chapter 7, page 1, of the Region B DMERC Supplier Manual.

4. Providers submitting on ANSI 837 continue to have delays in receiving Level 1 and Level 2 response files. This problem causes unnecessary delays in claim submission. Explanations for the delays are inconsistent. When can providers expect to see resolution to overall problems rather than resolution to individual situations?

   AdminaStar has experienced issues impacting the stability of clearinghouse HIPAA transaction reporting services provided to our DMERC Region B Medicare customers. We are working closely with CMS and the clearinghouse staff on stabilization efforts as we continue to ensure Medicare timeliness standards are being achieved. The major impact resulting from the clearinghouse instability are delays in returning the necessary 837 Claim transaction response report (997) and the DMERC Level 2 IG/Medicare edit report. Progress has not been at the desired pace, but never the less, progress has been made. There have been

several recent stabilization enhancements completed allowing the DMERC transactions and reports to be received, processed, and distributed within expected timeliness standards. Our stabilization efforts will continue and further transaction and reporting enhancements are scheduled for implementation in mid July and early August 2004.

AdminaStar emphasizes that reporting delays have been encountered, but claims continue to be processed and paid within all Medicare timeliness standards.

5. Why does E0144 continue to be downcoded to E0143?

   E0144 will continue to be downcoded to E0143. The medical policy on Walkers states that the medical necessity for a walker with an enclosed frame (E0144) compared to a standard folding wheeled walker (E0143) has not been established.

6. New Cervical Traction Devices LCD, which becomes effective on 7/1/04: I noticed that on the new Cervical Traction Devices LCD, under the "Indications and Limitations of Coverage and/or Medical Necessity", 7th paragraph, it states: "Cervical traction applied via attachment to a headboard (E0840), devices not requiring a frame of stand (E0855), or free-standing frame (E0850) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (E0860). If an E0840, E0850 or E0855 is ordered and the medical necessity criteria for cervical traction devices are met, reimbursement will be based on the allowance for the least costly medically appropriate alternative (E0860)." Does this mean that for all practical purposes, the allowed amount for E0840, E0855 and E0850 now becomes the same as the allowed for E0860? If not, what must be documented to show that an E0840, E0855 or E0850 is the least costly medically appropriate alternative?

   Yes. All claims for E0840, E0850, and E0855 will be paid comparable to E0860. The DMERC received no comments about this when the draft policy was posted during the public comment phase of the policy development process.

7. Medicare is denying repair parts if they have been replaced in the last several years. We have denials on parts replaced where the most recent replacement part is over 3 years ago. How long does Medicare expect parts to last on new HME (specifically a wheelchair) or on replacement parts they already paid for? If we explain why parts could not be repaired and must be replaced will Medicare pay for replacement or do we obtain an ABN in this case?

   General information about repairs and replacement can be found in an article beginning on page 5 of the September 2003 Region B DMERC Supplier Bulletin. More details are needed about the item being repaired/replaced in order to provide a more specific response.

8. When delivering equipment to a patient in a facility prior to discharge, who according to Medicare Compliance Guidelines can sign delivery ticket if patient is unavailable? If a nurse or caregiver signs, are they taking financial responsibility, or are they just signing that item was received?

   If the beneficiary is unavailable, a designee is allowed to sign the delivery ticket. A designee is defined as *"Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."*

   Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signing of a delivery ticket simply states the item was received, it does not assign financial responsibility.

9. When we call voice response regarding claim status, if the claim is paid, it gives a check number. When we receive the Medicare EOMB the number we were given is the statement number and not the actual check number. If we are trying to trace an actual check that we have not received, but system states is paid, we need the actual check number. Why does VRU not give the actual check number?

   When calling the Interactive Voice Response Unit (IVR), when a particular claim has been paid, the IVR provides the supplier with the actual check number for the particular claim in question. If the IVR is

giving statement numbers to suppliers instead of the actual check numbers for paid claims then this is an issue Medicare has not experienced in the past with the IVR. Please contact Customer Service at 877-299-7900 and provide the Customer Service Representative with examples so this issue can be researched.

10. When calling Medicare eligibility, why can you no longer use the voice response system when the patient has a number after the alpha letter at the end of the Medicare number?

    The Interactive Voice Response Unit (IVR) has never had the capability to allow suppliers to retrieve eligibility information for Medicare beneficiaries whose Medicare number has a numeric number after the alpha character. This is a function of the IVR Unit that AdminaStar Federal is currently researching as a possible upgrade to the system. An implementation date for this new upgrade has yet to be determined. Suppliers will be notified of IVR upgrades via Listserve and on the AdminaStar Federal Web site located at www.adminastar.com.

11. Why is the Medicare VRU system down so often, almost daily, lately?

    AdminaStar Federal tracks issues and escalates trends that surface. These issues are then investigated and a resolution is put into action or an estimated time is given regarding when a resolution will be implemented.

Enteral/Parentral/IV Therapy

12. What is the current status and position on payment for Natrecor for CHF?

    Natrecor is denied as not medically necessary when administered with an infusion pump. We have not seen studies from the medical literature documenting the safety and effectiveness of the drug when administered on a repeated basis, unsupervised, and in the home setting.

Respiratory Care Equipment/Oxygen Therapy

13. When supplying disposable CPAP filters (A7038) to a patient, can a three or six month supply be provided and the filters billed with a span date? CPAP filters are a small item and providing more than one month's supply allows the patient to change the filter in a timely manner, without having to re-order a filter every two weeks, or a month.

    Billing up to a 3 month supply is acceptable. It is advisable to use span dates.

14. According to the oxygen policy, a stationary oxygen system can be covered if there is a decrease in arterial PO2 more than 10mmHg (from an arterial blood gas) or a decrease in arterial oxygen saturation more than 5 percent for at least 5 minutes taken during sleep (using an overnight pulse oximeter) with symptoms attributable to hypoxemia. Does the test still have to fall in the guidelines of 55 and below or 88% and below? What ABG or saturation do we put on the CMN?

    The test does not need to meet Group 1 criteria. The lowest saturation that is reached for at least 5 minutes should be recorded on the CMN. The CMN will fail the CMN edits. The claim will have to be submitted as an appeal and should be accompanied by a copy of the test report as well as information from the patient's medical record indicating symptoms or signs which the physician attributes to nocturnal hypoxemia.

15. If a beneficiary is going home from a skilled facility, can we use the pulse oximetry done by the facility to qualify the patient for oxygen and use that facility as the testing facility on our CMN?

    Yes, as long as the test was performed no earlier than 2 days prior to discharge.

16. For oxygen qualifying purposes, what is the definition of "at rest" and "with exercise" (deals with oxygen SAT's)?

    "At rest" means awake and not moving. "With exercise" means while moving.

17. On the March 31st open door meeting regarding the Wheelchair Policy, it was stated that Medicare was under no legal obligation to pay for anything used outside the home. Regarding Home Oxygen, I would interpret this to mean Medicare only has a responsibility to pay for Oxygen used in the home. I asked, does this allow us to bill separately for travel oxygen when the customer leaves the home for any extended time?

    When oxygen is medically necessary within the home, its use both inside and outside the home is covered. Information about coverage for travel oxygen can be found in the Oxygen policy, beginning on page OXY-7 in Chapter 17 of the Region B DMERC Supplier Manual.

18. Initial 02 CMN had a duration of 6 months. We obtained a new sat 3 weeks after the CMN expired. Do we need:

    i. Initial CMN dated the date of the new sat and go to break in service (see policy OXY-10). If this is the case, do we then do a recert in 12 months?
    ii. Recert CMN dated 6 months from initial date with new test date (done 3 weeks after the fact)? See policy OXY-4.
    iii. Revised CMN dated 6 months from the initial date with new test date (done 3 weeks after the fact)?

    When you cross-reference the policy to the September 2003 Region B DMERC Supplier Bulletin, which has the oxygen "scenarios," it is not clear how to handle this.

    The correct answer is (i). This is addressed by scenario #8 in the September 2003 Region B DMERC Supplier Bulletin article. Yes, a recertification would be needed in 12 months.

Prosthetics/Orthotics

19. Please explain Coding Verification Review (CVR) done by the SADMERC. Can a coding change be retroactive?

    When a manufacturer or supplier requests Coding Verification Review (CVR) from the SADMERC, the date that the SADMERC and DMERCs made the determination is included in the response letter. That date would be considered the effective date of the determination. The SADMERC lists that date when it posts the determinations to the Product Classification Lists on their web site. If it is an initial CVR, the SADMERC determination could be applied by the DMERCs to claims with dates even before the determination date. We would need to see copies of the SADMERC letters to comment on the specific issues raised in the question.

20. Diabetic shoes and inserts – can a supplier give the product to the Medicare recipient after we receive a dispensing order and then have the CMN signed and then bill, or should we obtain a dispensing order, and signed CMN before giving the product to the recipient.

    There is no CMN for diabetic shoes and inserts; rather there is a Statement of Certifying Physician. This can be signed after the patient receives the items, as long as there is documentation in the patient's medical record prior to the dispensing date that supports the statements made on the form. The product can be dispensed after receiving the dispensing order. The codes cannot be billed with a KX modifier until after the supplier has the physician-signed Statement of Certifying Physician and it indicates that coverage criteria are met.

Rehabilitation Equipment

21. Region B DMERC published on their Web site on March 25, 2004 an article titled "Power Wheelchairs and POVs" under "What's New". CMS has instructed the DMERCs to remove the clarification published on December 9, 2003. The published article of March 25, 2004 states "CMS also indicated that some of the information in the article – e.g., guidance on documentation and information on DMERC medical review strategy and probe reviews – is still valuable to suppliers. This material will be published by the DMERC in another publication." What is the status of the upcoming publication?

    It has not yet been decided how that information will be conveyed to the general supplier community. That information is conveyed individually to suppliers who are being looked at with a probe review or other types of pre-pay or post-pay medical review.

Ostomy / Urological / Medical Supplies

No questions were submitted.

Diabetic Monitoring and Supplies

No questions were submitted.

Documentation / Regulatory / Miscellaneous

22. If a patient's disability limits his writing ability, can he initial or make a mark on the delivery ticket? Will it also be acceptable on the assignment of benefits?

    It is acceptable for the patient to sign a delivery ticket and/or the Assignment of Benefits form with initials or a mark due to disability or literacy issues. In this scenario, the document in question should list the signature, address, and position/relationship of a witness.

23. In chapter 5, there are several new pages on ABN. The fourth paragraph states "To be held liable for payment means that the beneficiary will be liable for payment 'out-of-pocket' or through other insurance coverage (e.g. employer group health plan coverage), or through Medicaid or other federal or nonfederal payment source." Does this mean we need an ABN if we expect Medicare to deny so we can collect from another payer? For example, in Indiana we can collect from Medicaid when Medicare denies. I have no intention of collecting from the patient, especially in the Medicare/Medicaid scenario. I already have Indiana Medicaid PA approving my service but they won't pay without the Medicare denial. If I have no intention of collecting from the patient, why do I need a waiver to collect from another insurance plan?

    An Advanced Beneficiary Notice (ABN) is a written notice a supplier gives to a Medicare beneficiary before providing items and/or services that are expected to be denied by Medicare.

    The requirements attached to the ABN are in place to ensure Medicare beneficiaries are informed of possible financial responsibility. Therefore the requirements for having an ABN in place, when appropriate, is applicable to all suppliers dealing with Medicare beneficiaries regardless if the beneficiary has a payer secondary to Medicare.

24. If a beneficiary moves to Region B from another region and we obtain the other providers CMN how should the claims be submitted? There is no break in service but Region B would have no CMN's on file.

    This issue is being researched by AdminaStar Federal.

25. We have received conflicting information on PPS—if there is a home health episode, is the nursing agency responsible for supplying/billing ALL required supplies—even if additional supplies are not related to the diagnosis which requires home health?

    Yes. Per the CMS Web site FAQ:

    "A quadriplegic who performs intermittent catheterization 6 times/day. He/she develops a decubitus ulcer which requires home health services for wound care. Under Prospective Payment System (PPS), I understand the wound supplies would be included in the PPS episodic rate. What about the catheter supplies that are unrelated to the home health agency 'plan of care' i.e. wound care?

    The law is specific at Section 1895(b)(1) of the Social Security Act about what is included in the new payment rate. All services covered and paid on a reasonable cost basis as of the date of enactment of the Balanced Budget Act of 1997 (BBA 97), including medical supplies, are to be paid on the basis of a prospective payment amount under HHA PPS. The statutory language specifically refers to the inclusion of medical supplies in the prospective payment rate. We believe the statute requires the inclusion of costs of non-routine medical supplies in the episode rate.

    Furthermore, the law is specific at Section 1842(b)(6)(F) of the Act, as amended by section 305 of the Balanced Budget Refinement Act of 1999 (BBRA 99) regarding the consolidated billing requirements. Routine and non-routine medical supplies furnished to a patient during the time he or she is under a plan

of care of a home health agency are bundled into the episode rate. Therefore, in the example, the home health agency is responsible for providing the catheter supplies while the patient is under a plan of care even though those supplies are unrelated to the plan of care. The PPS episode payment will reimburse the HHA accordingly."

26. Documentation for medical necessity for orthotics (for various diagnosis/needs) – how do we know if the documentation we are obtaining prior to the order is enough to prove the medical necessity. There is nothing clear in the Medical policies regarding what is required. We obtain a dispensing order, notes from the chart or therapy and also a signed detailed Doctors sheet, what else should we get? We have seen a large increase in the number of denials and we try to only take solid orders. Please help.

    General information about the type of documentation that must be in a patient's medical record is found in Chapter 17, General Information section, page 6 of the Region B DMERC Supplier Manual. The DMERC would need to know what specific items are being provided in order to provide additional guidance.

27. Do you know if and when the capped rental and IRP HCPCS lists will be put back in the Payment Policy chapter of the Region B DMERC Supplier Manual? We miss them.

    Region B removed the codes due to the frequency of coding changes. However, this information can be found on the fee schedule posted to the AdminaStar Federal web site www.adminastar.com.

HCPCS CODES	MD	CA	DC	IL	IN	MD	MI	MN	OH	VA	WI	WV
K0001	RR	CR	$54.62	$54.62	$54.62	$54.62	$54.62	$50.49	$54.62	$54.62	$53.09	$54.62

28. CMS PIM Transmittal 61 clearly states that "If a supplier utilizes a delivery/shipping service or mail order that is able to provide the actual date of receipt by the beneficiary or designee, such date shall be considered the date of service on the claim." However, a recent Region B DMERC "News You Can Use" article stated: "If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim." Why is there a discrepancy between the CMS transmittal and the Region B education? At a recent Region C Seminar in Lexington, the Ombudsman's education was in agreement with the CMS Transmittal. Please clarify.

    The transmittal in question, CR 3030, was revised April 9, 2004 to state *"If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim."*

Other

29. We still seem to receive denials when the patient transfers from a HMO to Medicare because there is a delay in Medicare updating the patient's records. Can you let us know how long the process of updating the records is supposed to take and if there are any suggestions on how we can avoid these denials? We have examples of claims if necessary.

    The processing guidelines have been updated to instruct the processors to check the HMO record and correct the CMN file if necessary. If you continue to encounter problems please contact Provider Assistance at 877-299-7900.

30. How do we bill if the patient lives in Region B, but their POA lives in another region? All Social Security documents go to the POA in the other region. Where does the patient's address go and does the POA's address need to be on the claim form also? How is the region determined, by the address that the documents are sent to or the patient's physical location? We have a specific case that has billed several ways and still has not been paid.

    DMERC jurisdiction classification is determined by the beneficiary's permanent address as it is listed with Social Security.

31. We have reviewed the recent article provided by the National Supplier Clearinghouse (NSC) clarifying the qualifications needed for fitting diabetic shoes, both off the shelf and custom. However, consultants in the field

are telling us that all we need is the training from the manufacturer to be able to provide these. Even at the most recent OAMES Education Seminar reviewing Medicare coverage, a consultant in Akron did not lead us to believe we needed these certifications. Please clarify.

On May 16, 2004 the National Supplier Clearinghouse (NSC) retracted the statement that they posted concerning qualifications for dispensing therapeutic shoes and inserts.

32. A DME provider A authorizes its marketing staff to entice Medicare Beneficiaries to switch their oxygen services over to them from DME Provider B. The marketing staff tells these potential customers that if they switch from Provider B that Provider A will give them a free portable Ultra-Sonic nebulizer. Provider A rationalizes this policy by saying that most of the oxygen patients use nebulizers already so this is an item that is closely associated with the patients Medicare qualifying diagnosis for oxygen reimbursement. The patient then calls Provider B and tells them they are switching to Provider A unless Provider B will also supply the same Ultra-Sonic nebulizer for free. Instead, Provider B is in a difficult position and must decide to supply the free Ultra-Sonic nebulizer or call foul and argue that this is simply another form of kick back to entice a Medicare Beneficiary and should be reported to the OIG. Provider B knows full well that the referral source and patient will choose to do business with Provider A from now on if Provider B does not provide the free Ultra-Sonic nebulizer. Question: Who is right and what should Provider B do to defend its customer base?

    Per the CMS Web site Section 11286(b) of the Social Security Act (42 U.S.C. 1320a-46(b), provides criminal penalties for knowingly offering, paying, or soliciting renumeration in order to induce Medicare business. Suppliers found guilty of offering or receiving a "kickback" can be subjected to criminal or civil penalties. The offense can be classified as a felony and punishable by fines of up to $25,000 and imprisonment for up to five (5) years. The law also provides that "prohibited business practices" which in turn may be construed to be kickbacks can be handled under administrative authorities provided to the Office of Inspector General which can result in a supplier being excluded from Medicare participation. Suppliers may contact Provider Assistance at 1-866-299-7900 to report information to the Benefit Integrity Unit.

33. If a private insurance buys a wheelchair for a patient and the patient then becomes covered under Medicare, do you need a CMN for that wheelchair in order to do repairs since Medicare only repairs medically necessary patient owned equipment? If so what would the initial date on the CMN be? What other methods could be used to establish medical necessity when Medicare did not purchase the equipment?

    Pending