Jurisdictions B, C and D Councils Combined A-Team Questions
October 2016

Enteral/Parenteral/IV Therapy

1. Regarding revised MLN Matters SE1521 which CMS provides clarification to the MACs and QICs for post payment reviews on or after April 18, 2016. This article was revised on May 9, 2016, to provide updated information regarding redetermination requests received by Medicare Administrative Contractors (MACs) or Qualified Independent Contractors (QICs) on or after April 18, 2016.

When a supplier responds to a complex prepayment review, complex post-payment review or automated post-payment review what documentation do the MACs and QICs require the supplier to include for the limited review? For simplification purposes, can the supplier provide only the documentation necessary to support the initial denial, or must the supplier continue to submit **all** supporting documentation?

Examples:

a. If initially denied for DIF issues, can we submit the supporting documentation for the DIF only?

b. If initially denied for invalid POD, can we submit the supporting documentation for POD only?

c. If initially denied for DWO signed and dated after the date of service, can we submit only the dispensing order that authorized the supplier to ship prior to the start date?

DME MAC Response: The DME MACs recommend that suppliers utilize the self-service tools and secure web portals to determine the reason for denial and then only submit what is necessary for a Redetermination request.

The DME MACs cannot comment on what is required by the QIC. Any questions related to their processes or policies should be sent directly to them for a response.

Respiratory Care Equipment/Oxygen/PAP/Other

2. A customer who has started PAP therapy has an interruption in billing during the first 90-days, either an inpatient or in a SNF. The interruption has caused the customer to fail their objective evidence within the first 90-days. Are there any options in this instance that would allow the initial 90-days to be extended without a repeat study?

a. Same scenario as above with RAD. Are there any options in this instance that would allow the initial 90-days to be extended without a repeat study?
b. Jurisdiction B suppliers have been told that if they have documentation of the admission and discharge dates they can use that number of additional days to meet compliance. Is this correct?

DME MAC Response: The continued coverage requirements outlined in the PAP and RAD policies are very different. Therefore, the premise that a new sleep study is required if continued coverage requirements for a RAD are not met is incorrect.

If a beneficiary is admitted to an inpatient hospital or skilled nursing facility (SNF), during their 12 week trial period, the trial period is suspended. The 12 week trial period applies to PAP use in the home setting and excludes time spent in an inpatient or SNF. The PAP trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day), resumes when the beneficiary returns home.

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3. How long is a sleep study valid for the initial set up, first time use of PAP therapy? Suppliers are receiving conflicting answers across the 4 DME MAC jurisdictions.

DME MAC Response. There is no specific timeframe for which a sleep study is valid; however, it is good medical practice to initiate therapy as soon as possible after a diagnostic test. This is to ensure that the beneficiary's medical condition has not changed making the planned therapy ineffective.

4. MM9741: Documentation for Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Claims for Replacement of Essential Accessories for Beneficiary-Owned Continuous Positive Airway Pressure Devices (CPAPs) and Respiratory Assist Devices (RADs):

a. Does this apply to replacement machines where Medicare paid for the original machine? Example: Patient transitions to a new company, new provider obtains a script and recent notes. If a patient requests replacement machine down the road they would need to back track to obtain sleep study, initial medical documentation showing initial medical need, etc…If this information is not available would the patient need to go though a whole new sleep study? If so, this may create a short term solution but will not help in the long run and could interrupt therapy if a machine stops working after 5 years.

b. Medicare paid for the initial machine (13-months). Patient is requesting replacement supplies. Provider is able to obtain physician documentation demonstrating medical necessity for the continued need for PAP supplies and a prescription. Several months later they need to replace the machine. What documentation would be necessary to replace the machine?

i. Initial sleep study
ii. Initial order
iii. Proof of compliant 12 week trial period i.e., re-evaluation notes and download
iv. Face to face documentation within 6-months prior to new order
v. New 5-element order

DME MAC Response: The instructions provided in MLN Matters Article MM9741 are related to the replacement of PAP and RAD related necessary accessories used with beneficiary-owned PAP and RAD devices that were covered and paid for by Medicare FFS.

The MLN does not provide any information regarding the replacement of the PAP or RAD device itself. Suppliers should reference the applicable policy regarding the documentation requirements for the replacement of the device.

5. We have provided extensive education to the sleep labs and pulmonary physicians that oxygen coverage is contingent on an underlying lung condition. Furthermore, when OSA is suspected, a titration study must show OSA is resolved.

We would like to request a "Dear Physician Letter" or similar education directed to the physicians that clearly communicates why ordering oxygen for an OSA patient (specifically as a result of non-compliance with PAP therapy and/or inability to tolerate PAP therapy) will not justify oxygen or qualify as a covered lung condition.

DME MAC Response: The DME MACs have previously published several educational resources on this topic including the following:

- "Dear Physician" letter titled; "*Home Oxygen Initial Qualification Testing*"
- Joint publication article titled; "*Frequently Asked Questions: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea*".
- Collaborative Medicare Part A, Part B and DME MAC joint article titled; "*Physicians! Are You Ordering Oxygen For Your Patient?"*

The DME MACs believe that the education provided on this topic is sufficient to educate referral sources regarding the coverage of oxygen in patients who have a diagnosis of OSA.

Prosthetics/Orthotics

6. When a patient is treated with a knee orthosis for a specific diagnosis and later requires a different knee orthosis due to a change in condition/and or diagnosis, will

the second knee orthosis be denied as not medically necessary due to same or similar restrictions?

a. An example of this scenario is if a patient has a knee injury which warrants coverage of a knee immobilizer (L1832) to prevent further injury and subsequently has surgery which warrants the coverage of a double upright knee orthosis (L1845) to provide stability during the post-surgical period. Would this scenario result in a potential denial for same or similar purposes.

b. Another example is when a patient is fitted with an off the shelf unloader (K0901) and does not have success with the brace because it is determined a custom brace was really needed. If the physician writes a new prescription and thoroughly documents the need for a custom brace, will this be a potential denial due to same or similar restrictions?

DME MAC Response: A change in medical condition or a change in the physiological condition of the patient may be considered justification for a new device. The medical record must be sufficiently detailed and documents the medical need for a different device.

In the scenario presented in (b), the requirements for a custom fabricated brace must be met. The LCD says (in part):

CUSTOM FABRICATED KNEE ORTHOSES (L1834, L1840, L1844, L1846, L1860):
A custom fabricated orthosis is covered when there is a documented physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Examples of situations which meet the criterion for a custom fabricated orthosis include, but are not limited to:

1. Deformity of the leg or knee;
2. Size of thigh and calf;
3. Minimal muscle mass upon which to suspend an orthosis.

Although these are examples of potential situations where a custom fabricated orthosis may be appropriate, suppliers must consider prefabricated alternatives such as pediatric knee orthoses in beneficiaries with small limbs, straps with additional length for large limbs, etc.

If a custom fabricated orthosis is provided but the medical record does not document why that item is medically necessary instead of a prefabricated orthosis, the custom fabricated orthosis will be denied as not reasonable and necessary.

Suppliers should consult the Knee Orthosis LCD for additional coverage, coding and documentation requirements.

7. Can a list or chart of the “same and similar” L codes be provided (which codes conflict with each other)?

DME MAC Response: The DME MACs will take the suggestion for education under advisement.

Rehab Equipment

8. Once an ALJ is overturned (favorable) or an escalation is favorable, what is the average time frame for the DME MACs to adjust payment? Some providers have favorable determinations from July 2015 with no adjustment to the claim for payment as of September 1, 2016.

DME MAC Response: The Medicare Claims Processing Manual, Chapter 29, Section 330.3 and 330.4 outlines the ALJ effectuation process.

In summary, the AdQIC receives the decision from the ALJ office and forwards a notice of effectuation to the DME MAC when the decision is wholly or partially favorable. If the decision specifies the amount to be paid the DME MAC has 30 calendar days to effectuate the payment. If the amount to be paid is not specified and the DME MAC must compute the amount to be paid, the amount must be computed as soon as possible, but no later than 30 calendar days of the effectuation notice.

The DME MAC only effectuates based on documentation received from the AdQIC; the DME MAC does not effectuate based on correspondence from any party to the ALJ hearing.

9. Will CMS be paying interest on the PAMPA codes that were underpaid for dates of service January 1, 2016 – June 30, 2016? Since the processing system was not updated to reimburse at the correct allowable until July 5, 2016.

DME MAC Response: No, Change Requests CR9520, CR9586 did not instruct the DME MACs to pay interest on claims affected by PAMPA. The direction stated that the DME MACs were to adjust claims for dates of service on or after January 1, 2016 – June 30, 2016 that were processed and paid at the adjusted fee schedule amounts.

10. When an ADMC approval is obtained prior to delivery and claim submission, what scenarios would cause that claim to be developed with an ADR? Would you please explain why that claim could later be denied for medical necessity (not due to lack of proof of delivery, etc.) if the codes on the claim are consistent with the ADMC approval?

DME MAC Response: The CMS Internet Only Manual (IOM), Publication 100-08, *Medicare Program Integrity Manual*, Chapter 5, Section 5.16 outlines the ADMC process and does not prohibit a Medicare auditing entity from performing either a prepayment or post payment review. In most cases we would expect the ADMC determination and the audit decisions to be consistent; however, ADMC only considers the reasonable and necessary requirements for the item. There are additional Medicare requirements that must be met, some of which are not examined during ADMC process. Consequently, a claim may be denied upon additional review. If you have specific concerns regarding either an ADMC determination or audit decision you should contact the appropriate DMD MAC Provider Contact Center for further assistance.

11. The DME MACs recently jointly published an article titled; "Miscellaneous HCPCS Codes Require Additional Information". Among the items required when submitting a claim for a miscellaneous code were the Supplier Price List (PL) amount, and the HCPCS code of the related item (if applicable). Can we get some further clarification on these 2 required items?

a. Previously the MSRP was requested. If the intent is to have the supplier submit their price, rather than the manufacturer's suggested price; that would normally be the same as the billed price. Can this be explained, and is MSRP still acceptable?

DME MAC Response: The type of pricing information required was changed from Manufacturer's Suggested Retail Price to Supplier's Price List. The MSRP is no longer acceptable. Supplier Price Lists are listed in the Internet Only Manuals (IOM), Medicare Claims Processing Manual, Chapter 23, Section 60.3 as a resource that can be used in developing gap-filled DMEPOS fees. We are aware that in most cases, the Supplier's Price List and the submitted amount will be the same.

b. Please provide an example of a HCPCS code of a "related item"? Are you looking for the base code that the option is used with (if that is the scenario)? If not, please explain what this would be.

DME MAC Response: Yes we are looking for the base code that the option is used with if that is applicable. Example billing a wheelchair accessory code with HCPCS code K0108, provide the HCPCS code for the wheelchair base that the accessory goes on.

12. Multiple Modifiers. With items on the PAMPA list added to the mix, there are now many times when more than 4 modifiers are needed to bill a code/line item. For example, a power tilt (E1002) requires NU, KH, BP, KX and KU modifiers. Since it exceeds 4 modifiers, an overflow modifier (99) is needed. Providers have been given conflicting information how to bill these lines. Would each please list the preferred

way to bill the code and first 4 modifiers, and exactly what needs to be included in the narrative field. Please use these two examples E0973 with NU, KU, KY, KX, RT, LT; E1028 with NU, KH, BP, KU, KY, KX, LT, RT or with RR, KH,KU, KY, KX, RT, LT

a. Is there a "correct" order for the modifiers – especially for the first three modifier fields? Will the processing system kick out or deny the line if the kX is not one of the first 3 modifiers?

   DME MAC Response: The primary pricing modifier - RR, NU, UE - should always be placed in the first modifier position. Any secondary pricing modifiers - (KH, KI, KJ, BP, BR, etc.) should be placed in the section modifier position. Any information modifiers should be placed in the third modifier position. If the claim line requires more than four modifiers the overflow modifier 99 must be placed in the fourth modifier position.

b. When modifiers are entered in the narrative field, do we list all, or just the ones that do not fit on the claim line?

   DME MAC Response: All modifiers should be repeated in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or in Item 19 of the paper claim form.

13. Modifier KU is the new modifier that became effective in July 2016. Will any of the DME MACs be publishing more detailed instructions on when to bill with KU, KY or KY, KU? It would be most helpful if a chart could be published that would show the specific accessory codes and modifier combinations that are billed with the various power and manual wheelchair bases. Will any of the DME MACs be posting a functional Modifier tool on their website?

DME MAC Response: Supplier should also see CMS Publication SE1614 for additional details on the use of the KU and KY modifiers. The DME MACs will take the suggestion for education under advisement.

Medical Supplies

14. Questions concerning HCPCS code A4450 (non-waterproof tape) and A4452 (waterproof tape). The PDAC was contacted concerning clarification for non-waterproof and waterproof tapes. When assigning HCPCS A4452 ('waterproof tape") the tape must state "waterproof", and that "water resistant" is not waterproof.

A representative from PDAC said that Noridian is aware of the controversy surrounding HCPCS A4450 and HCPCS A4452 concerning the definition of

"waterproof" and that PDAC has assigned HCPCS A4452(waterproof) to non-waterproof tapes. For example:

Item ID	Item Name	Manufacturer Name	Correct HCPCS Code	DMEPDAC	Waterproof/Non-Waterproof
4209	REBILL HYPAFIX TAPE 2"X10YD 412-825	SMITH & NEPHEW	**A4450**	A4452	Non-waterproof
4211	HYPAFIX 6" X 10YD TAPE	SMITH & NEPHEW	**A4450**	A4452	Non-waterproof
MSC4006	MEDFIX 6" X 11YD TAPE	MEDLINE	**A4450**	A4452	Non-waterproof
1527-1	TRANSPORE TAPE, 1"X10 YDS	3M	**A4450**	A4452	Non-waterproof
1527-1 cs/10/120ea	TRANSPORE TAPE, 1"X10 YDS (Case)	3M	**A4450**	A4452	Non-waterproof

Although Medicare will accept A4452 waterproof tape for non-waterproof tape, some Medicaid's and other insurances do not. Are you able to provide any further insight into this matter?

DME MAC Response: Per the PDAC, no product is completely and permanently waterproof. Some just resist soaking through longer and better than others.

1. There is no industry standard definition
2. There is no official Medicare definition
3. The predicate products varied

Therefore, PDAC allows Manufacturers to self-designate.

15. What are the requirements with Medicare when a beneficiary obtains their Medicare benefits as a Secondary Payer in the middle of a third party insured capped rental period? For example, a beneficiary renting capped rental equipment who has other insurance primary, becomes eligible for Medicare as secondary while in the middle of that primary insurer's capped rental period. Following the rules of the primary insurance, we are in the middle of the rental period and expecting six more rental

payments before that insurer will consider the capped rental “purchased”. In addition, the primary insurer requires Capped Rental DME to be billed with the Pricing modifiers (KH, KI and KJ).

a. Since we would be billing the remainder of the capped rentals to the primary insurer with the KJ modifier, would Medicare as the secondary payer allow the KJ modifier in this instance and pay the claim through the remaining six months of this capped rental period?

   DME MAC Response: Yes.

b. Would Medicare as the secondary payer require the DME supplier to obtain a new face-to-face (if required), a new DWO and a new delivery ticket prior to billing Medicare for the capped rental equipment?

   DME MAC Response: Yes. When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare Fee-for-Service (FFS) program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary's medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

c. If the supplier is not able to obtain any of that information when the MSP is added to the beneficiary, would the DME supplier be able to execute an ABN with the beneficiary?

   DME MAC Response: An ABN may be issued when the supplier believes that Medicare may not pay for an item or service which is expected to be denied as not reasonable and necessary by Medicare. As a reminder the reason Medicare is likely to deny must be specific or the ABN may be determined to be invalid. A statement indicating that you were unable to obtain information would not be sufficient.

16. When a non-participating provider is unable to obtain a signature on the Assignment of Benefits (AOB) because the beneficiary is unwilling to sign the AOB, would Medicare consider the following statement to be a valid ABN reason: “Beneficiary failed to provide a signed beneficiary authorization of benefits”?

a. What is the consequence of not having an AOB? Is it a liability on the supplier necessitating an ABN or does it negate the ability to file a claim at all(as in the case of statutorily non covered services)?

DME MAC Response: If the beneficiary refuses to sign the AOB you will be unable to bill Medicare Fee For Service (FFS). Assignment rules are unrelated to the ABN. Therefore, having the beneficiary sign an ABN would not allow you to submit the claim to Medicare.

17. What is the process a Supplier can take to get an appropriate PR denial when they initially submit their claim to the DME MAC in the following situation:

Supplier adds a GA modifier because the patient requested over quantity on a supply order, and a valid ABN is obtained. The claim line is submitted with the normal modifiers, the GA modifier and a specific narrative. Claim lines are rejecting with a B20 or CO45 rejection. Supplier has to appeal to try and get the appropriate PR rejection, even though the provider included the GA modifier and the correct narrative with the claim.

Examples:
Jurisdiction B, CCN #16245819339000
Jurisdiction C, CCN #16203738478000
Jurisdiction D, CCN #16217833980000

DME MAC Response: Effective July 1, 2015, CMS issued instructions to the DME MACs that when a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary from a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim (see MM9079). A beneficiary cannot be held liable for a duplicate claim.