Jurisdiction B Council Questions
Sorted by A-Team
July 25, 2013

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.gov.

Home Medical Equipment

1. **We have received denials for negative pressure wound therapy (NPWT) audits but do not fully understand the explanation provided by customer service. Where in the NPWT Local Coverage Determination (LCD) can we find that home health records or other documentation showing NPWT being used in the home dated after the date of service is required? We have seen several denials for "Medical records do not support vac in outpatient setting" for initial setups and reoccurring rentals.**

   Answer: We agree that the narrative that is given is difficult to translate, and would ask for the specific claim denial for review.

Enteral/Parenteral/IV Therapy

No questions submitted.

Oxygen Therapy

2. **Previous Question and Answer (Q&A) states: If a beneficiary started on his/her oxygen while on the Managed Care Plan, "all rules apply for Fee-for-service (FFS) Medicare when transferring to it, EXCEPT there is one waiver -- the oxygenation test to qualify does NOT**

have to have been dated within 30 days of the FFS initial service." New delivery ticket requirements were addressed but what about other documentation?

a. **Does the patient need to have a repeat face-to-face? When does it need to occur?**
b. **Does the patient need to have repeated testing to "re-qualify" or can you use the test from when the patient was qualified under the Managed Care Plan?**
c. **Is a new/revised Certificate of Medical Necessity (CMN) required?**
d. **What date should be used on the CMN (if required)?**
e. **Do we need to get new delivery paperwork/other documentation prior to billing FFS Medicare?**
f. **If a beneficiary is in the 36-60 month oxygen rental do we need to get a new proof of delivery ticket signed or will the signed delivery ticket for the tank delivery suffice?**

Answer to all parts: All beneficiaries who are new to Medicare and who have been using oxygen must be considered as coming from a different payer and are to be treated as an initial enrollee to FFS Medicare. The only exception is for beneficiaries coming out of a Medicare Advantage (MA) plan who have been on oxygen, in which case the initial qualifying oxygen test which is to be done 30 days prior to the initial date, is waived. The most recent qualifying test obtained while in the Health Maintenance Organization (HMO) may be used. All other requirements must be met that are in the LCD and Policy Article. Please refer to the Bulletin Article "Medicare Eligibility and Documentation Requirements for DMEPOS Items Obtained Prior to Medicare Eligibility" published by all jurisdictions in March, 2013.

Respiratory Care Equipment

No questions submitted.

Prosthetics/Orthotics

3. **The entire prosthesis is denied, the patient did not sign an Advance Beneficiary Notice of Noncoverage (ABN). Medicare did not pay for the service and the denial is in appeal. Six months later the patient needs supplies/repairs to the prosthesis that he has. Is the patient responsible for all new service on this prosthesis? Is patient not eligible for any new services while the denial is going forward?**

   Answer: This item would be considered to be denied until a reversal occurs. The Medicare Program does not pay for repair of previously denied equipment or prostheses. These

instructions are outlined in the Internet Only Manual (IOM) 100-02, Medicare Benefits Policy Manual, Chapter 15, Sections 120.D and 110.2.A.

Rehab Equipment

4. **Reading MM8181 regarding competitive bid modifiers, it appears that the KY modifier must be used on complex rehab bases (manual and power) if the client lives in a competitive bidding area (CBA), even though these are not bid items. Please provide a list of all codes affected by the KY modifier, with a detailed instruction on how these need to be applied. And please communicate this with all providers of complex rehab, who may not be reading the competitive bid-specific instructions since complex rehab is exempt.**

   Answer: Standard power wheelchairs and manual wheelchairs are included in the Round 2 Standard (Power and Manual) Wheelchairs, Scooters, and Related Accessories product category. Since some of the accessories included in this product category can also be used with non-competitively bid wheelchair base units, a supplier providing an accessory for a non-competitively bid wheelchair base unit to a beneficiary who permanently resides in a CBA will need to use the "KY" informational modifier in order for the claim for the item to price correctly.

   Complex rehabilitative power wheelchair bases were bid in Round 1 but not in Round 2. The "KY" modifier is used with accessory codes that are used with complex rehabilitative power wheelchair bases that are *not* Round 2 (or subsequent Round) competitive bid items, but *were* bid in Round 1 of the DMEPOS Competitive Bidding Program.

   When billing for an accessory used with a complex rehabilitative group 2 power wheelchair (K0835 thru K0843) or complex rehabilitative group 3 power wheelchair (K0848 thru K0864) (bid in Round 1; not bid in Round 2), if a claim is for a beneficiary who permanently resides in a CBA, then bill the item with a KY modifier. The payment basis is the fee schedule (-9.5%).

   Since the "KY" modifier indicates that the accessory is used with a non-competitively bid base unit, if the claim is billed without the "KY" modifier, claims submitted by a non-contract supplier will be denied and claims submitted by a contract supplier will be reimbursed based on the single payment amount.

Ostomy/Urological/Medical Supplies

5. **We are seeing an increase in A4353 (Straight catheters and insert trays) development letter requests. We submit the requested information yet the charges are usually denied for CO-50 (medical necessity). We process and send the redetermination with back-up and most often**

the CO-50 denial is upheld. We then obtain additional documentation, process and send a reconsideration that appears to now be denying again. The documentation includes history and physical, physician orders and progress notes, refill request, and proof of delivery (POD) information. This healthcare common procedure coding system (HCPCS) code does not have a set utilization guideline from the payer. What documentation will be acceptable to the payer?

Answer: Please read the policy "Urological Supplies" for an understanding of the requirements for coverage of A4353. Claims examples are always helpful.

Diabetic Monitoring and Supplies

6. **Is a face-to-face and new prescription required if a beneficiary is changing suppliers as part of the Competitive Bidding National Mail Order for diabetic testing supplies effective July 1st?**

   Answer: Yes, Program Integrity Manual (PIM) Chapter 5, Section 5.2.4 requires a new order if there is a new supplier. Additionally, if an item is on the specified list under the ACA 6407, it shall require a face-to-face examination within 6 months of the initial order in addition to a Written Order Prior to Delivery (WOPD) as conditions of payment, effective with orders written on or after July 1, 2013.

Documentation/Regulatory/Miscellaneous/Other

7. **If a claim is denied indicating the CMN was not received, can the CMN be submitted through Re-openings or are we required to go through Redeterminations?**

   Answer: There are two scenarios here: If a claim receives an American National Standards Institute (ANSI) 173 denial (no CMN received) the supplier should resubmit the claim with the appropriate Initial CMN. The supplier should not be requesting a reopening or a redetermination to correct this type of denial. However, if a claim was selected for review (an Additional Documentation Request [ADR] was received by the supplier) and the ADR included a request for the CMN but the supplier failed to submit the CMN with the requested documentation, the supplier may request a redetermination. When requesting a redetermination, suppliers must remember to submit all the requested documentation – not just the CMN.

8. **Our proof of delivery documents are multiple pages. The beneficiary signs on the last page and prior pages indicate "Continues on next page;" however, we were told that every page of the POD must be signed. Where can we find documentation of this requirement?**

Answer: The POD must be signed and dated. If the POD is an extended document, it must be clear that it is continuous and is one document. Requirements for the POD may be found in the PIM Chapter 4, Section 26.1:

> "Suppliers may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include: 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. The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply shall be the date of service on the claim."

The use of page numbers would be one method to assure that a multi-page document is considered to be one document with one signature and date. We always welcome claim examples and would be most interested in seeing this review response.

9. **If we receive the 5-Element Order and the only item that is missing is the physician's National Provider Identifier (NPI), can we write the NPI on the order if it is in Provider Enrollment, Chain and Ownership System (PECOS)?**

   Answer: The term "Five Element Order" is not one that is defined to our knowledge by CMS. If instead, you mean a "Written Order Prior to Delivery" (WOPD) that is applicable to ACA 6407, a completed WOPD may not be altered once it is signed and dated by the physician. However, the supplier may request a new order from the physician with this information included or have the physician correct the original WOPD properly according to accepted methods of modification. This may only be done prior to the delivery of the item, as per the statute.

Competitive Bidding

10. **If we are a provider that was awarded a competitive bidding contract, our understanding is that we have to take assignment on the claim.**

    a. **If the client does <u>not</u> have a face-to-face (F2F) examination, but otherwise meets the medical necessity criteria as stated in the LCD, is our action to get an ABN and bill assigned using the KK, GA and the EY modifiers?**

Answer: Claims for items outlined in Affordable Care Act (ACA) 6407 will receive a statutory denial (beneficiary liable) when the F2F requirements have not been met. The ABN does not apply to statutory exclusions; therefore, the GA modifier is not applicable. While an ABN may be provided to the beneficiary as a courtesy to inform him/her of the expected denial and financial impact, modifier GA should not be used, and the beneficiary is not required to select an option or sign the ABN. Items that are expected to deny on the basis of a statutory requirement should be billed with modifier GY. Modifier EY should be appended only when the supplier does not have an order for the item. Modifier KK should be appended to codes for options or accessories provided for use with a complex power wheelchair base when the beneficiary's permanent residence is in a Round 1 CBA. This includes replacement parts furnished in conjunction with the repair of beneficiary-owned base equipment. For beneficiaries who reside in a Round 2 CBA, there are no situations that require the use of modifier KK.

b. If the client <u>does</u> have a F2F, but does <u>not</u> meet the medical necessity criteria as stated in the LCD, is our action to get an ABN and bill assigned using the KK, GA and the GY modifiers?

Answer: If the beneficiary does not meet the medical necessity criteria stated in the LCD, the supplier should execute an ABN citing the specific reason for the expected denial. When an ABN is properly executed, the supplier should append modifier GA. Modifier GY is not appropriate in this situation as modifier GY indicates that an item is statutorily noncovered. The GA and GY modifiers should never be reported on the same claim line. Competitive bidding modifier KK is applicable to beneficiaries whose permanent residence is in a Round 1 CBA. Modifier KK should be appended to codes for options or accessories provided for use with a complex power wheelchair base when the beneficiary permanent residence is in a Round 1 CBA. This includes replacement parts furnished in conjunction with the repair of beneficiary-owned base equipment. For beneficiaries who reside in a Round 2 CBA, there are no situations that require the use of modifier KK.

c. In the two situations described above, could we bill NON-assigned?

Answer: Per IOM, Medicare Claims Processing Manual, Chapter 36, 50.1 - Electronic Submission of Claims and Mandatory Assignment:

> "All DMEPOS Competitive Bidding Program claims are subject to mandatory assignment. Mandatory assignment denotes that a supplier shall accept the Medicare payment as payment in full for their services. The beneficiary's

liability is limited to any applicable deductible plus the 20 percent coinsurance. “