Jurisdiction B Council A-Team Questions
Sorted by A-Team
May 16, 2013

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Home Medical Equipment

1. When a beneficiary is unable to get out of bed and to the bathroom in a timely manner and risks having a urinary or fecal accident, whether the patient can ambulate with or without a walker, or if the patient is in a wheelchair, would this scenario constitute "room confined" and qualify the patient for a bedside commode?

   Answer: If the beneficiary does not have mobility equipment and cannot get to the bathroom in a timely fashion then the beneficiary would be considered room confined. On the other hand, if the beneficiary does have mobility equipment and can get to the bathroom within a timely manner then they would not be considered room confined, but if they cannot get to the bathroom on time with the use of MAE, they would qualify for coverage of the bedside commode.

Enteral/Parentral/IV Therapy

No questions submitted.

Respiratory Care Equipment/Oxygen Therapy

2. Why are oxygen test results obtained while the patient is in a skilled nursing facility (SNF) not considered valid? The Part A facility is very qualified to perform the tests and the patient is in need of oxygen services upon discharge from the nursing facility (NF). Unless the patient is taken straight to their physician upon discharge in order to have another test

done to qualify them for oxygen, the patient is either going to be forced to pay for the oxygen they need themselves with an Advance Beneficiary Notice of Noncoverage (ABN), or worse, the patient will chose to go without their needed oxygen.

Answer: Please refer to question/answer number six of the May 3, 2012 Jurisdiction B Council Q&A document as well as question six of the January 24, 2013 Q&A document.

3. If a beneficiary currently has an oxygen system (E0431) that has reached the 36-month rental cap and the physician sends us an order to put the patient on a portable oxygen concentrator (E1392), do we get paid for the portable concentrator or will this be denied as same or similar? Codes E1392 and K0738 are not included on the same/similar reference chart.

   Answer: This would not result in a same/similar denial; however, there would be no payment for the portable equipment. After the 36-month rental cap has been reached, no additional rental payments may be made. Suppliers may be reimbursed for contents for liquid and gaseous equipment and maintenance and servicing of transfilling equipment and concentrators.

4. The LCD for positive airway pressure (PAP) states the following regarding home sleep tests (HST): "An HST is performed unattended in the beneficiary's home using a portable monitoring device." We have some medical doctors (MD) that are performing these HSTs on their patients while the patient is in the hospital, wanting to use the results to qualify the patient for PAP equipment. While the LCD does state the test is to be performed in the patient's home, the MD's contention is that these tests can be done anywhere as they are portable. Are HST's that meet Medicare guidelines able to be performed in any other arena other than the patient's home in order to qualify the patient for PAP equipment? Are HST's able to be performed at a Truck Stop to qualify OTR truckers?

   Answer: A facility may use a Type II, III, or IV HST in their sleep lab as an alternative to a diagnostic PSG for qualification for CPAP reimbursement. Just as a reminder, since oxygen coverage has gotten tangled with PAP reimbursement, Type II, III, and IV HSTs are diagnostic only, therefore any oximetry results obtained with one of these tests may not be used to qualify a beneficiary for oxygen payment. Untreated or inadequately treated OSA does not meet the "chronic stable state" requirement for oxygen qualification. Only titration PSG oximetry obtained *after* the optimal parameters have been determined and obtained using PAP may be used (which would suggest that the OSA is being addressed with the PAP).

Updated answer to provide additional information following discussion during meeting:
The CMS National Coverage Determination Manual, 100-03, Section 240.4.1.B sets out where each type of test may be done:

1. *Type I PSG is covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.*
2. *Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.*
3. *Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.*
4. *Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.*

5. If you set a Medicare beneficiary up with an A7034 nasal mask and it does not work after 2-3 weeks, can you then set them up with an A7030 full face mask and bill it? If so, would be an acceptable reason (mask leak, etc.)?

   Answer: Medicare covers one mask every three months. It is expected that the choice of a mask should be accomplished during the study time. If a second mask is billed within the three-month period, it will deny due to same/similar/frequency edits.

Prosthetics/Orthotics

6. In reference to the list of healthcare procedure coding system (HCPCS) codes that require PDAC verification, what HCPCS should be used if the product is not listed on the product classification list? For example, the posterior leaf ankle-foot-knee (AFO) distributed by Donjoy would fit the description of L1930. It is not on the product classification list so what HCPCS should be assigned to that product? L2999?

   Answer: If the item is not coded per PDAC and not required to be verified, then suppliers should code the product based on the qualifying long narrative description that best matches the product being provided but should not use a code requiring verification. Suppliers may consult with the PDAC regarding alternative codes to use. The MACs often publish articles about correct coding. Finally, the policy often contains instructions about coding. It is suggested that all of these resources be used before a supplier unilaterally selects a code.

Rehab Equipment

7. How do you calculate payment on miscellaneous codes such as E1399 or K0108? Percentage of MSRP? What is used if manufacturer does not have a MSRP? Has this calculation changed recently?

   Answer: The payment calculation for these items has not changed. Items billed under E1399 or K0108 are paid based upon individual consideration. The MSRP information provided is used to assist the contractor in determining the supplier's reimbursement. If an item does not have an MSRP, this should be indicated in the NTE segment. The DME MAC has processes in place to address this issue. Additional information regarding pricing can be found in the CMS Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 20.

8. Once National Competitive Bidding (NCB) Round 2 goes into effect on July 1, 2013, if a beneficiary in a competitive bidding area (CBA) has a rental power wheelchair - K0823 as an example - that was delivered by a non-contract supplier in the months preceding the start of Round 2 and that non-contract supplier decides NOT to grandfather any standard mobility items, a contract supplier for that CBA is obligated to accept the beneficiary and provide a new rental PWC, coordinating with the noncontract provider on pick up of the old chair and delivery of a chair from the new provider. But PMDs have very specific medical necessity documentation requirements that include compliance with specific time frames including the 120 days from the face-to-face (F2F) date to delivery date. How would the contract provider be able to obtain all the required documentation and deliver a new power wheel chair (PWC) on a timely basis?

   Answer: If a Medicare beneficiary chooses to switch suppliers and obtain rental equipment from a new contract supplier instead of a grandfathered supplier OR if a non-contract supplier decides not to grandfather items that were rented at the time the Program is implemented, the current supplier and the new contract supplier must coordinate the pick-up and delivery of the equipment so that service to the beneficiary is not disrupted. The current supplier should provide all supporting documentation, such as the physician order or Certificate of Medical Necessity (CMN) when applicable, to the new contract supplier.

   The pick-up and delivery should be on the first anniversary date that occurs after July 1, 2013, or another date agreed to by the beneficiary. The anniversary date is the date of the month on which the item was first delivered to the beneficiary by the non-contract supplier. It is the date when a new monthly rental period begins.

Under no circumstances may the supplier discontinue services by picking up a medically necessary item(s) prior to the end of a month for which the supplier is eligible to receive a rental payment, even if the last day of the rental month occurs after July 1, 2013.

For more details, please refer to the *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet.* For information regarding competitive bidding requirements, suppliers should contact the Competitive Bidding Implementation Contractor (CBIC) or refer to the CBIC Web site at www.dmecompetitivebid.com.

9. A very large power wheelchair provider has essentially shut down. Other providers are getting calls from beneficiaries who have rental chairs from that provider. The beneficiaries need repairs but the 13-month payment cap has not been reached so Medicare won't pay a different provider for the repairs. The original provider is unresponsive to the beneficiaries' calls. Are there any options for these beneficiaries to get repairs or maintenance on these rental power mobility devices (PMD)?

   Answer: National Government Services is looking into this issue.

10. The Competitive Bidding Implementation Contractor (CBIC) issued a fact sheet that states that Round 2 non-contracted hospitals may provide and be paid for standard folding manual wheelchair rentals if provided by the hospital on discharge. They are to bill using modifier J4. Please confirm that the J4 modifier would be valid for the full 13-month rent-to-purchase capped rental period. Also, please discuss if there is any distinction between the hospital as a single entity providing and billing for rental wheelchairs and a hospital owned DME provider (with a separate Tax ID).

    Answer: Modifier J4 must be included on each monthly rental claim for the standard folding manual wheelchair submitted by the hospital.

    As for the second part of your question, the CBIC Fact sheet states the following:

    > ***Medicare hospitals have the option to furnish competitively bid walkers or folding manual wheelchairs to their own patients without submitting a bid or being awarded a competitive bid contract if the following requirements are met:***
    > - ***The walker or folding manual wheelchair must be furnished by the hospital to its own patients during an admission or on the date of discharge; and***

- *The walker or folding manual wheelchair must be billed to a DME Medicare Administrative Contractor (DME MAC) using the DMEPOS billing number that is assigned to the hospital.*

Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker or folding manual wheelchair to ensure timely and accurate claims processing.

This exception does not apply to hospital-owned DMEPOS suppliers or DMEPOS suppliers that are only affiliated with a hospital **[emphasis added].**

For additional information regarding competitive bidding requirements, please contact the Competitive Bidding Implementation Contractor or visit their Web site at http://www.dmecompetitivebid.com.

Ostomy/Urological/Medical Supplies

No questions submitted.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

11. We participated in a Medicare "Oxygen Medical Policy" webinar on March 26, 2013. During this webinar there was the discussion of having medical records and what needed to be submitted for redeterminations or audits. The presenter stated that providers should submit a physician's log or an attestation if the physician's signature was illegible. They then stated that in the case of electronic medical records we should have the "protocol" for those records. We were unable to ask questions during the Webinar so we contacted customer service on March 26, 2013 and were told that we are responsible to provide the clinic/physician/hospital protocols for medical records. We were then directed to the CMS manual Pub. 100-07, Transmittal 47. This is an "Interpretive Guidelines for Hospitals" and discusses the hospital's requirements for medical records. When I asked what we were to do if we were unable to obtain a clinic's protocol, I was told that in those cases we should send the medical records to the physician and have him sign and date each electronic medical record. Is it really the responsibility of the medical supplier to provide Medicare with the "protocol" for medical records that any given medical professional uses?

Answer: Electronic signatures and dates must be indicated as being signed and dated electronically, e.g. the signature might say, "Electronically signed by Robert R. Smith, 04/24/13." If there is no indication that the signature on the medical record was provided electronically, then a signed and dated physician attestation statement from the author indicating he/she is the author of the medical record or the facility's electronic signature protocol will be accepted.

12. Requirements for the face-to-face, state it has to be documented in the chart by the physician as he would normally document. This documentation must be signed and dated by the physician or a representative of the physician. Can this documentation be dictated in a letter or an electronic document that is electronically signed and dated or must it be handwritten?

    Answer: Medical records may be electronically signed and dated by the physician but must meet Medicare electronic signature guidelines. A letter of attestation from the physician regarding what is actually in the medical records is not a substitute for the medical records per IOM 100-08, Chapter 5, Section 5.7.

13. Has the requirement for the Statement of Certifying Physician been removed from both Group 1 and Group 2 pressure reducing support surfaces policies?

    Answer: Yes. The Statement of Certifying Physician requirement has been removed for all the support surface policies.

14. What supporting documentation is required for a 5-year oxygen reasonable useful lifetime (RUL) replacement in regards to the two items listed below?
    a. New dispensing order?
       Answer: A new dispensing order is not required; however, a new detailed written order is required when an item is replaced.

        i. What time frame will be required – within 30 days prior to the new initial date or would you look to the continued need aspect and allow a written order within the past 12 months?

           Answer: A new detailed written order is required when the item is replaced. The PIM, Chapter 5, Section 5.3.1 states, the "Initial Date" found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician

does not give a specific start date, the "Initial Date" would be the date of the order.

b. Documentation of oxygen need and usage:
    i. Would you be looking for notes within the past 30 days or past 12 months?

    Answer: The standard language documentation as laid out in the oxygen policy states, "*Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.*"

15. Patient is setup with oxygen while on traditional fee-for-service (FFS) Medicare and 12 months later changes to a Medicare HMO, then 12 months later changes back to FFS Medicare. Please advise on proof of delivery (POD) requirement:
    a. Would new delivery paperwork be required upon changing back to Medicare FFS?
    b. Would you consider this a break in service and can we begin billing FFS Medicare on the first anniversary date after re-entering FFS Medicare and the original delivery from their initial FFS Medicare suffice as proof of delivery?

    Answer: We will address two possible situations here.

    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. However, all FFS Medicare rules do apply. Therefore, a new Proof of Delivery is necessary – but this does not require you, as the supplier, to go and pick up the equipment and deliver a new one. It is your business decision on how to accomplish this and your contractual obligations with that Medicare Managed Care company would potentially apply here. It is acceptable for FFS Medicare purposes to have your service technician go to the beneficiary's home and service it, to be sure it meets the 5 year RUL requirement, and at that time get a Proof of Delivery signed (of course documentation is required to show this should an audit occur).

    Per the Oxygen and Oxygen Equipment Policy Article, when there has been a break-in-billing/Part B payment without break-in-medical necessity, i.e., if the beneficiary enters a hospital or SNF or joins a Medicare HMO and continues to need/use oxygen, when the beneficiary returns home or rejoins Medicare FFS, payment resumes where it left off. In this situation, the beneficiary is not entitled

to a new rental period. Example: If at the end of FFS Medicare payment month #12, the beneficiary transferred to a Medicare Managed Care Plan, and he/she continuously used this equipment AND there was no change in the equipment (such as going from a concentrator to gaseous oxygen), then 12 months later, the billing would pick up with month #13. Under this instance, the original Proof of Delivery is allowed. However, suppliers are expected to obtain proof of delivery documentation to validate delivery of *any* DMEPOS item. Therefore, when equipment is picked up and new or different equipment is provided, suppliers must obtain POD.

16. The Certificate of Medical Necessity (CMN) status information on Connex is not always accurate. Will the CMN status for same/similar equipment be corrected in the near future?

    Answer: National Government Services is investigating to determine if there is an issue with the same/similar feature of Connex. If issues are found, steps will be taken to correct the issues.

17. We are able to verify whether an ordering/referring physician is enrolled in the Provider Enrollment, Chain and Ownership System (PECOS) through the IVR. Are there any plans to add PECOS verification to Connex?

    Answer: Provider Outreach and Education has requested that the Connex team add this feature; however, there are no plans to add the feature at this time.

18. What ANSI denial codes will be used on the Medicare Summary Notice when the ordering/referring physician PECOS edit denials begin on May 1, 2013? Will it be a PR or CO denial?

    Answer: CMS has delayed implementation of Phase 2 of the ordering/referring physician edits until further notice. Phase 2 edits will not be implemented on May 1, 2013.

19. Can a DMEPOS supplier that is a participating provider and not in a competitive bid area refuse to take on a traditional FFS Medicare customer for a particular product or service (such as external infusion pumps) because of poor reimbursement rates if they provide external infusion pumps to customers with commercial insurance.

Answer: As long as the supplier gives notice, they can choose to not provide an item(s) any longer. The notice should be given at least 30 days prior to any change. The supplier should also notify the National Supplier Clearinghouse (NSC) with a "Change of Information" application to remove the item from their specialty list.