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Medicare

Jurisdiction B Council A-Team Questions
Sorted by A-Team
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Home Medical Equipment

1. The RA and RB modifiers will help with replacement and repair claims, but we still struggle with situations where the customer has previously received the equipment and it was paid for by commercial insurance. We have a couple of people (high risk spinal cord injury) that have been on E0277 for years. They become Medicare primary and when the Group 2 fails they don't qualify for a Group 2 because they don't have a wound. They haven't failed on a Group 1, etc. Do we have to get the denial and then go through the appeals process?

   ANSWER: A group 2 support surface is covered to assist in the healing of a pressure ulcer. The coverage criteria in the Pressure Reducing Support Surfaces – Group 2 Local Coverage Determination specify that once the wound has healed, coverage would end. At that time, it would be appropriate to switch the patient to a good quality Group 1 support surface. Group 1 support surfaces are designed for patients who are at risk for the development of pressure ulcers.

2. We delivered a semi-electric hospital bed (E0260) to the patient and a month later the physician ordered the patient a Group 2 Support Surface (E0277). At that point, we picked up the mattress from the semi-electric bed. Since we will now be billing for the E0261, do we need to get a new order or can we bill from the existing order for the E0260 and change the HCPC on the claim to be the E0261?

   ANSWER: For an item to be covered by Medicare a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. If you obtained an order for a semi-electric hospital bed with a mattress prior to the initial delivery and the only thing changing is the type of mattress due to the patient's worsening condition a new order for the hospital bed would not be needed.

3. What is the correct code to utilize when billing for two elevating legrests with the purchase of a power wheelchair (e.g. K0822)? Should it be billed as 1 unit with HCPC K0195 or 2 units with HCPC E0990?

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ANSWER: When a power wheelchair is purchased, it would be appropriate to use 2 units of service of code E0990 for elevating legrests. HCPC K0195 would be used when the related wheelchair base was being billed as a capped rental item.

Enteral/Parentral/IV Therapy

No Questions Submitted

Respiratory Care Equipment/Oxygen Therapy

4. If a Medicare HMO patient changes to fee-for-service Medicare and they met the coverage criteria for a Positive Airway Pressure device prior to 11/1/08, will the Medicare patient be grandfathered in or will the supplier be required to start over with a face-to-face, sleep study, download, follow-up? What if they were setup after 11/1/08 and the Medicare patient transitions from a Medicare HMO to fee-for-service?

   ANSWER: As stated in the December revision of the Positive Airway Pressure Devices LCD, if a beneficiary received a PAP device prior to enrollment in fee-for-service Medicare, accessories and/or a replacement device would be covered if there is (1) documentation of a prior sleep test that meets Medicare coverage criteria and (2) documentation of a face-to-face evaluation by a physician after Medicare FFS enrollment. Please refer to the LCD for additional details on the National Government Web site at: www.NGSMedicare.com.

5. If we send a patient-owned CPAP machine to be repaired and the machine is no longer under warranty, so the manufacturer sends us a refurbished machine for the patient because it was better to replace the machine rather than repair it. It was repaired, but it was replaced with a refurbished model rather than replace all the parts that needed to be repaired. It is less than 5 years so Medicare will not begin a new capped rental period. How is this to be billed to Medicare? In this case, the DME Company is still charged for the "repairs" even though the CPAP was replaced with a refurbished CPAP.

   ANSWER: Medicare reimbursement for repairs is available only for specific parts and for the labor time involved in the actual repair. If a manufacturer receives an item needing repair and chooses to provide a refurbished item, they must determine the parts that would be needed to repair the original machine and the time that would be involved in doing that repair. That is what should be billed by the supplier to the DME MAC. Medicare will not reimburse a flat rate for a refurbished item.

6. If a patient has been on oxygen therapy for more than 5 years, elects to receive new equipment, and begin a new capped rental period what documentation will we need to start a new capped period?

a. New testing?
b. Modifiers attached to initial claim?
c. Will we need to send the initial claim to break-in-service?
d. Will we need a new initial CMN?

ANSWER: A response to this question will be provided as soon as the information becomes available. At this time we are waiting for further instructions from CMS.

7. Please confirm how a supplier is to determine the volume or quantity of contents we are obligated to provide for portable oxygen contents. The supplier manual refers to the provider delivering all the oxygen the "patient needs". Does the patient need to include convenience use, including vacations, day trips, and recreation?

   ANSWER: If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the patient uses; Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed. Reimbursement for oxygen contents do not restrict the patient from participating in activities outside of the home.

8. The manual refers to "delivery" as being the responsibility of the supplier. How many deliveries are required for portable oxygen cylinders? If the provider delivers enough portable cylinders as defined by the supplier standard once per month or per quarter, and the patient wants more frequent deliveries, can the supplier bill the patient for excessive delivery frequencies?

   ANSWER: The supplier must provide whatever quantity of oxygen the patient uses and may <u>not</u> bill the beneficiary for delivery of the cylinders. If the beneficiary requires more contents for a paid month than were initially delivered, the supplier must deliver the contents and cannot bill for these contents. The supplier may bill on a set monthly schedule as long as the quantity of oxygen contents that are needed during that month have been supplied on or before the date of service.

9. Can a non-participating provider notify the patient that claims for contents of stationary or portable systems will be billed on a non-assigned basis after the 36 month oxygen cap date? Is it the same for travel oxygen?

   ANSWER: The Code of Federal Regulations, Section 414.226(g)(3) requires that before furnishing oxygen equipment, the supplier must disclose to the beneficiary its intentions as to whether it will or will not accept assignment of all monthly rental claims for the duration of the rental period. A supplier's intentions could be expressed in the form of a written agreement between the supplier and the beneficiary. However, after the 36-month rental period has been reached, the non-participating supplier may choose to accept assignment on a claim-by-claim basis.

10. Can a supplier bill a patient for accessories if the patient requests accessories that are a) not ordered by a physician, or b) more than the required monthly or quarterly volume needed?

    ANSWER: Suppliers must furnish what the beneficiary needs for each month. The oxygen rental payment includes reimbursement for the equipment, oxygen contents, maintenance, and supplies and accessories such as tubing or a mouthpiece, and other services necessary for furnishing oxygen and oxygen equipment.

11. For oxygen patients who relocate, what is the supplier's responsibility to "arrange" for oxygen? Does that specifically mean that the cost of the oxygen provided by another company is to be paid for by the Medicare recognized provider? What if the patient relocates to a location that has no willing local provider to offer contents or service? In the past we were not responsible to make these arrangements

    ANSWER: It is the supplier's responsibility to arrange for oxygen for all patients that they service. This could involve "arranging" for another supplier in the area to provide the contents, or arranging for delivery of the contents from their own location. If the beneficiary "relocates" before the end of the 36-month rental period, he/she should work with their supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at their new place of residence.

    If the beneficiary "relocates" after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore, must make arrangements for the beneficiary to continue receiving oxygen services at their new place of residence. Again, this could involve "arranging" for another supplier in the area to provide the contents, or arranging for delivery of the contents from their own location.

12. Oxygen CMN, question #2 regarding when and how test results were obtained. Choices include tests performed in chronic stable state, within two days of discharge, or other circumstances. What would constitute "other" circumstances (i.e., patient with pneumonia qualified results wise but not in chronic stable state or within 2 days of discharge)? Patient wanted to stay home to recover, but they did pass away. Claims were denied and are currently level two appeals.

    ANSWER: For question #2 on the oxygen CMN, option 3 – "under other circumstances" – would be situations of acute hypoxemia in an outpatient setting. A patient with pneumonia would be an example of this. NCD 240.2 says "For those patients whose initial oxygen prescription did not originate during a hospital stay,

blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of an acute illness or an exacerbation of their underlying disease."

13. When a new Medicare patient is placed on oxygen will suppliers be required to notify the patient of their intent to accept or not accept assignment throughout the capped rental period? Can the supplier change assignment after the 36 month period as long as the Medicare patient is notified in writing? Can you change the assignment status during the 36 months?

    ANSWER: The Code of Federal Regulations, Section 414.226(g)(3) requires that before furnishing oxygen equipment, the supplier must disclose to the beneficiary its intentions as to whether it will or will not accept assignment of all monthly rental claims for the duration of the rental period. A supplier's intentions could be expressed in the form of a written agreement between the supplier and the beneficiary. However, after the 36-month rental period has been reached, the non-participating supplier may choose to accept assignment on a claim-by-claim basis.

14. Are suppliers required to place Medicare patients on a downloadable machine to be compliant with the requirement of 4 hours per night on at least 70% of the nights in a 30 consecutive day period?

    ANSWER: The supplier will usually be required to have a downloadable machine in order to document that the compliance requirement specified in the PAP LCD has been met. There are some limited exceptions. Please refer to questions 7-11 in the PAP Supplier FAQ document that was published in December 2008 for additional information on adherence monitoring. The document can be located on the National Government Services Web site under teleconference materials or by pasting the following link into your internet browser: http://www.ngsmedicare.com/NGSMedicare/DMEMAC/EducationandSupport/Teleconferences/FinalPAPLunchandLearn.pdf

Prosthetics/Orthotics

15. For silicone prosthesis, is the prescription required to say silicone on it for it to be valid or is the prescription valid with breast form or prosthesis on it?

    ANSWER: Since there are multiple types of breast prostheses, the detailed written order must specify a silicone breast prosthesis for HCPCS code L8030 to be covered.

16. The LCD for External Breast Prosthesis indicates that a diagnosis of a mastectomy is required for coverage. As technology improves and early detection becomes more prevalent and lumpectomies are becoming more prevalent. Is this an acceptable diagnosis for mastectomy forms?

ANSWER: Breast prostheses are eligible for coverage for a patient who has had a partial mastectomy – e.g., a lumpectomy.

Rehab Equipment

17. Can the information necessary to complete a specialty evaluation be taken from documentation done prior to the face-to-face exam?

    ANSWER: No, the specialty evaluation should follow the face-to-face examination. The face-to-face examination is used to establish whether a power wheelchair is necessary. The specialty evaluation is used to identify the specific type of wheelchair and accessories that are needed.

18. If the specialty evaluation has all the information that the face-to-face must include, can a supplier use that document to meet both requirements as long as it is signed by the physician during an office visit with the patient and he agrees with it?

    ANSWER: Yes, as long as the person performing the specialty evaluation meets all the requirements specified in the LCD for Power Mobility Devices.

19. Many power wheelchairs are built with 4 caster wheels, 2 in the front and 2 in the back for stability. What is the appropriate way for a supplier to bill for all 4 casters when replacement is necessary for continued safe operation? It seems that 2 and sometimes all 4 are getting denied for too many services. The same holds true for all 8 bearings (2 per caster). ** Codes E2384, E2387, E2391, E2392 and E2395 are all on the Medically Unlikely Edit (MUE) list as a maximum of 2. These are all power chair-related caster codes. Can the edit list on these codes be revised to reflect that many power wheelchairs (PWC) do have 4 casters?

    ANSWER: A request to change the MUEs for the caster and bearings codes has been made to the Correct Coding Initiative (CCI) contractor. The correct way to bill is to indicate all units of service for the items that are provided on the same claim line. Until the edit is changed, if a claim line is denied, the supplier may request payment through the appeals process.

20. K0830 and K0831 were not included in competitive bidding. If accessories are added to these bases are the accessories billed with the KE modifier since (technically) they are not being used on a competitive bid item?

    ANSWER: Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid base equipment. Suppliers are encouraged to reference Medicare Learning Network (MLN) Matters

article 6270 which can be located at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6270.pdf.

21. Since Group 4 PWCs were not included in competitive bidding, what allowable will be used if reimbursed as a Group 3 equivalent? Will it be the 2008 allowable or 2009 allowable with the 9.5% reduction?

    ANSWER: Group 4 PWCs (K0868-K0886) have added capabilities that are not needed for use in the home. Therefore, if these wheelchairs are provided and coverage criteria for a Group 2 or Group 3 PWC are met, payment will be based on the allowance for the least costly medically appropriate alternative.

    If a Group 4 PWC is billed with a KX modifier payment at that time of initial automated processing will be based on the allowance for the comparable Group 3 PWC.

    Since Group 2 and Group 3 power wheelchairs were included in the competitive bidding, those items will receive the 9.5% reduction of the 4th quarter 2008 fee schedule, if the item was furnished on or after January 1, 2009. The 1st quarter 2009 fee schedule reflects this reduction.

22. Are there any instances where it is acceptable to charge a beneficiary for a service call? For example, the power chair isn't functioning and the customer needs us to go to their home to evaluate. Technically, Medicare doesn't pay for the assessment to see what is wrong, they just pay for any covered parts and the labor to actually do the repair. Can we charge to go to the home to diagnose the problem?

    ANSWER: Routine periodic servicing, such as testing, cleaning, regulating and checking of the beneficiary's equipment, is not covered. The owner is expected to perform such routine maintenance rather than a retailer or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary. Suppliers who perform such maintenance would utilize the HCPCS E1340 – Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.

Supplier's documentation would need to reflect what extensive maintenance was done.

23. If a therapist conducts part of the face-to-face examination, must the physician address all of the major coverage criteria (address ambulation, rule out least costly alternatives, etc.) in the chart entry from his/her face-to-face examination? Even if the therapist documents some or all of the criteria?

    ANSWER: If a part of the face-to-face exam is performed and documented by a PT/OT who has no financial relationship with the supplier, those parts of the exam do not have to be addressed by the physician in his/her exam.

24. Is a Display covered when used with an alternative drive device (Head Array, Mini Joystick, etc.)? What code would be used to bill for the Display? In the definition for E2310/E2311 what comprises the "indicator feature"?

    ANSWER: Payment for a display is included in the allowance for an alternative drive control interface. There should be no separate billing for the display. In the definition of E2310/E2311, the 'indicator feature" would be a display to show which function had been selected.

25. Does the following scenario meet the requirements regarding the need for a written order prior to delivery (WOPD) for wheelchair cushions and positioning accessories? (a) the 7-element written order for a PMD lists a base PMD (i.e. power wheelchair) but no accessories; (b) the detailed product description (DPD) prescription lists the wheelchair base and all accessories including cushions and positioning accessories but does not include all the elements of an order. The DPD prescription meets the policy requirements by listing the patient's name, the items that will be separately billed, supplier's charge, Medicare allowance – signed and dated by the physician but it does *not* include diagnosis or length of need. Medicare has communicated that the 7-element written order and the DPD are two distinct documents each with different content requirements. So, do the 7-element PMD order and DPD prescription *together* meet the WOPD requirements for the wheelchair seating items? Or must the wheelchair seating items be listed on the 7-element order by the physician or on a separate detailed written order?

    ANSWER: A detailed product description (DMD) for a power wheelchair contains all the elements required for a detailed written order prior to delivery. A diagnosis is not a required element on a detailed written order. A length of need is only required on a detailed written order for accessories or supplies provided on a periodic basis. A diagnosis and length of need are required on a 7-element order. http://www.ngsmedicare.com/NGSMedicare/dme_lcd/l27239_active_lcd.htm

26. If the beneficiary is well known to the physician the physician may refer the beneficiary to a licensed/certified medical professional (LCMP) for a functional evaluation to determine if a MAE should be recommended. If a PWC is recommended the beneficiary must have an appointment with the physician to discuss their mobility needs. At that time the physician may review the clinician's documentation, and concur, sign and date the evaluation. In this situation it is understood that the completion of the process and face-to-face date on the 7-element order would be the date of the exam with the physician. If the physician does not review, sign and date the LCMP evaluation on the date of the appointment but does so 2 weeks (or 2 months) later is the F2F date and the start of the 45 day "clock" the date the physician saw the patient or the date the physician concurred, signed and dated the LCMP evaluation?

    ANSWER: The 45 day period for providing the 7-element order and report of the face-to-face examination begins with the completion of the face-to-face examination. In the example given, if the physician signs and dates the LCMP's report 2 weeks after the visit with the physician, the 45 day period begins on the day that the physician signed the report.

Ostomy/Urological/Medical Supplies

27. Can a supplier bill for an extension drainage tubing, any type, any length, with connector/adaptor, for use with a urinary leg bag or an ostomy pouch, each (A4331) if the urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each (A4358) does not come with tubing? If not, how will the claim be denied, Contractual Obligation (CO) or Patient Responsibility (PR)? If we receive a CO can we obtain an Advance Beneficiary Notice (ABN)?

    ANSWER: No. In the situation described, A4331 may not be billed separately from A4358. A4358 includes drainage tubing whether or not the tubing is in the same package as the bag. Billing separately would cause a CO denial and an ABN would not apply.

Diabetic Monitoring and Supplies

No Questions Submitted

Documentation/Regulatory/Miscellaneous/Other

28. Are we part of the ICD-10 changes? Most of the listservs refer to Part A and Part B but don't mention the DME MACs, but the DMEPOS falls under Part B benefits?

    ANSWER: Yes, DMEPOS suppliers are part of the ICD-10 changes. The proposed rule for ICD-10 proposes to adopt the ICD-10 code set to replace the ICD-9 code sets in HIPAA transactions. All providers would be required to adopt the ICD-10 coding system to be HIPAA compliant. For more information related to this issue go to the CMS Web site at:
    http://www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage