Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **To understand situations of "the patient's condition changed" and when the need for the pump is resumed for chemotherapy patients would the following situations be considered a valid BIN/BIS that would allow for a new pump rental period:**

   Situation One: Chemotherapy is ordered for 12 cycles of 5FU every 14 days, so 6 months of chemotherapy.

   The pump is billed for 6 consecutive months and covered by the DMEMAC.

   Patient completed the therapy as ordered. Now, 3 months later during a clinic evaluation, the Physician determines another course of chemotherapy is appropriate and ordered (could be same chemo drug or different chemo drug) and the cancer diagnosis is the same for this patient.

   Would this be considered BIN/BIS to allow for a new INITIAL DIF for the pump?

   Situation Two: Chemotherapy is ordered for 12 cycles of 5FU every 14 days, so 6 months of chemotherapy.

   The patient starts the chemotherapy and in cycle 6 of 12, decides to take a "chemo break" due to complications and side effects of the chemotherapy. The chemo is discontinued for greater than 60 days, and then later resumed.

   Would this be considered valid BIN/BIS to allow for a new INITIAL DIF for the pump when the chemotherapy is resumed?

   Response: The break-in-service rule is not strictly counting days. There is also a component of a change in medical need (not just a temporary discontinuation in the same medical condition). In this case, the response assumes there is no change in medical condition (i.e., same cancer). A new capped rental period would not be allowed, even with the >60 days + remaining rental month days, because there was no change in medical need. If the second episode of chemo was prompted by a <u>different cancer</u> then a new capped rental would be allowed.

Medicare's break-in-service rules are used for the purpose of calculating continuous use and initiation (or resumption) of capped rental payments following an interruption in service and change medical need. This is outlined in detail in the DME MAC Supplier Manuals and educational materials produced by the DME MACs. Also see Medicare *Claims Processing Manual*, Chapter 20 §30.5.4.

2. **B4034 (syringe fed kits) are at times used on clients who only require hydration and not administration of enteral nutritional therapy. This is a situation when the item is statutorily non-covered. Other payers, including Minnesota Medicaid, will cover this type of usage but require a denial from Medicare to comply with coordination of benefits rules. If a non-payable DIF is submitted and the line is coded with GY, will the service line process with a PR or a CO denial? Is an ABN required to be on file to obtain a PR denial?**

   Response: Coverage is under the prosthetic benefit. In this situation, since only hydration support is being provided, the beneficiary does not meet the benefit category requirements for coverage. The GY modifier is appropriate for both the tube and the related supplies.

3. **A competitive bidding provider for enteral supplies considers clients as "Non-qualified" when their oral consumption of nutrition varies from day to day due to their cogitative state. Since each supplier has the responsibility of interpreting the broad language of the enteral medical policy as their own risk level tolerates, causing beneficiaries with developmental disabilities denied access to benefits within the CBA. These are not individuals with mood disorders, anorexia, or a refusal to eat. They are individuals with an inability to comprehend and perform the chewing and swallowing process on a regular basis, often found in individuals with dementia, severe developmental disabilities, or Alzheimer's. Smells, environment or food texture stimulate the brain to prompt consumption at some times but not others. Is it possible to consider as "covered" enteral therapy provided to a beneficiary who consumes oral nutrition several times per week but who will always require enteral therapy to maintain weight and strength commensurate with overall good health?**

   Response: The beneficiary must have either (a) permanent non-function or disease of the structures that normally permit food to reach the small bowel or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status. Enteral nutrition is covered under the Prosthetic Device benefit category. Prosthetic devices are items which replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. Individuals with dementia, developmental disabilities or Alzheimer's do not meet this definition unless the disease process results in a mechanical disruption such that food cannot reach the small bowel.

Education

No Questions

Home Medical Equipment

4. **CR 8952 recently issued by CMS provides guidelines for the repair of beneficiary owned equipment. Two of the guidelines given to the DMEMACs for repair claims are that "Contractors shall continue to adhere to the coverage and payment policies and procedures" and "Medicare contractors shall only assess the necessity of the DMEPOS repair when reviewing the claims and whether the equipment was fixed."**

   Do the DME MACs plan on issuing any guidance as far as how they will assess these claims or developing a repair policy since there is currently no formal repair policy?

   Response: When reviewing DMEPOS claims for repairs of beneficiary-owned equipment which was covered and paid for by Medicare, the CR is clear that the DME MACs shall address the continued medical necessity of the item being repaired and the necessity of the repair must be addressed in either the physician's or supplier's records. The Provider Outreach and Education Workgroup will consider a summary article to address repairs. The DMDs are not considering a formal repairs policy.

5. **The payment strategy for electric patient lifts (E0635) is designed to reimburse a purchase for nearly as much as a manual lift (E0630). The purchase pricing is within $100 for Minnesota. The insufficient reimbursement provides a barrier to access for this equipment for the clients who require it. What is the correct process to have the fee schedule reviewed?**

   Response: These are statutory requirements for determining fee schedules. The DME MACs suggest you contact the Division of DMEPOS Policy at CMS for the process to request revised processing.

Oxygen

6. **Please provide clarification on question 13 from the October, 2014 Q&A: If a patient has a qualifying oximetry test done during a covered Part A skilled nursing facility stay and the qualifying test was done 3 days prior to discharge to home.....how does the physician answer question 2 on the CMS 484 oxygen CMN?**

   Question 2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?

   What is the correct answer?

   This was the response: *For testing conducted in a skilled nursing facility (SNF) the physician should answer Question 1 if the patient is in a chronic stable state. The "within 2 days of discharge" as a surrogate for chronic stable state is only applicable to*

hospital scenarios (i.e., inpatient) per the Oxygen National Coverage Determination (NCD).

Please clarify if this should be the correct answer:

For testing conducted in a skilled nursing facility (SNF) the physician should answer Question 2 with 1) with the patient in a chronic stable state as an outpatient.

Response: If the patient is in a chronic stable state and the test was not performed during an inpatient hospital stay, answer 1 is correct. If the patient is not in a chronic stable state or within 2 days of discharge from a hospital, then the correct response on the CMN is answer 3 (Other).

7. **We have a customer that is currently on O2 and has a stationary and portable system. We are getting reimbursed from Medicare for the rental charges. The customer has requested to purchase a portable O2 concentrator to use for convenience. Medicare has not paid for a second portable, even if we have given a valid ABN stating that MC will only pay for one unit and the claim bills with a GA modifier. The Oxygen Billing Manual discusses that Medicare will not purchase equipment: The Medicare law prohibits payments for purchase of oxygen equipment. If the beneficiary chooses to purchase their own oxygen equipment, Medicare will not pay. How do we execute a proper ABN in order to bill the patient for the purchase of a POC?**

   Response: Only rented oxygen equipment is eligible for coverage. Purchased oxygen equipment is statutorily noncovered and an ABN would be voluntary. The supplier may bill with the appropriate modifier (GY).

Positive Airway Pressure (PAP)/Other Respiratory Care Equipment

8. **We understand that commercial insurance uses 1A scoring and Medicare 1b scoring. If a patient that is new to Medicare and had a sleep study through commercial insurance with 1a scoring BUT hypothetically had 60 obstructive apneas and only 5 hypopneas—are we able to use the study because the number of hypopneas would not change his AHI (at least not to make him not qualify) with 1B scoring (3% desaturation with hypopneas vs 4% desaturation with hypopneas)?**

   Response: For Medicare coverage, any sleep test must demonstrate the applicable requirements for Medicare. Alternative scoring rules are not applicable for justification of coverage.

Prosthetics/Orthotics

9. **The DME MACs issued a policy article on March 27, 2014, which details what custom fitting of a prefabricated orthotic involves prefabricated orthotics "requires the expertise of a certified Orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.**

In light of the recent CMS decision to not move forward with the proposed rule regarding the definition of minimal self-adjustment and individual with specialized training, will the response from the DME MAC's regarding our previous question (listed below) change?

Response: No it will not.

On July 11, 2014 CMS submitted a proposed rule defining individuals with "specialized training".

The comment period ends September 2, 2014, however on Friday, August 15th the Quality Standards were issued with a June date and Appendix C was updated to include a definition of "specialized training". How can the policy be changed prior to the end of the comment period?

This was the response: The Quality Standards and the DME MAC LCDs and related Policy Articles were based on existing regulatory language. CMS is considering changing that existing regulatory language by publishing a proposed rule for comment.

Rehab Equipment

10. **Complex rehab power wheelchairs are classified as capped rental items but retain the first month purchase option. Beneficiaries do occasionally elect the rental option on these chairs. However, there are no directions regarding billing instructions for this situation.**

    In Jurisdiction C, a provider had one claim deny when using a BR modifier and one claim pay when billing a complex rehab chair as a rental. On a subsequent call regarding a similar claim the provider was told that a modifier (NU or UE) was needed to establish whether or not the item was new or used. They were also told that a claim submitted without a BR modifier should be sent to Re-openings and request the modifier be added to claims for the first month.

    What are the proper modifiers (aside from the KX) to use on the initial and subsequent months for claims for a complex rehab chair that the beneficiary has elected to rent? Do all jurisdictions process claims using the same modifiers?

    Response: Purchase option for complex rehab chairs has not changed. The rental option requires BR RR KH (KI for the 2nd and 3rd month and KJ for months 4-13).

11. **A DMEPOS supplier reports that a hospital system does not supply custom molded seating devices when it is to be placed on a capped rental mobility device (example E1161 or K0004) because hospital system cannot be reimbursed for the custom seating when it is installed on rental chair. Since very few providers in the area manufacture custom seating, this is creating a barrier to services for the disabled community. If the mobility device cannot be purchased up front there is a catch-22 for the equipment supplier and the supplier of the custom seating system. Is Medicare aware of this conflict in policies?**

Response: The premise is incorrect that a purchased seating system cannot be placed on a rental chair base. Suppliers have been paid for purchased leg rests placed on rental chairs for 20 years. There is not a coverage or payment rule that precludes the provision of a purchase item contemporaneously with a rental item.

12. **May we have an update on receiving PMD prior authorization determinations by means other than mail?**

    Response: If the supplier submits the request via esMD using a participating health information handler (HIH) the response will be returned via esMD. Letters will be mailed in addition to esMD. Noridian also allows access to the PAR status and the unique tracking number (UTN) via the JD portal Endeavor.

13. **Please see following question from previous round, are there any updates?**

    Response: See below.

    A beneficiary needs a replacement seat upholstery code E0981. This beneficiary owns their own manual wheelchair; this wheelchair was funded by Medicare. The beneficiary reports that they are using the wheelchair daily as it had been ordered originally. The seat upholstery ripped from the frame and the chair is not safe or useable, and the beneficiary cannot use their equipment to get to the doctor until the seat upholstery is replaced. E0981 is listed as a HCPCS code requiring a face to face examination.

    a. Does this repair need to comply with the new WOPD/F2F requirements?

       Response: All items on the ACA 6407 list must comply with the statutory requirements

    b. If so, this appears to be contrary to the PIM language that indicates no order is needed for a repair.

       Response: Statute supersedes CMS interpretive manual instructions

    c. If the beneficiary wishes to pay out-of pocket to get the replacement seat upholstery immediately, may an ABN be obtained to advise the beneficiary that Medicare will not pay for the repair because it requires the F2F and WOPD?

       Response: Standard ABN rules apply. Therefore, since this is a statutory denial, an ABN is not required. However, an ABN may be used as a voluntary notice as a courtesy to the beneficiary. When an ABN is issued as a voluntary notice, the GA modifier must not be appended to the claim line.

14. **These questions clarify and further define the original question submitted to Jurisdiction C Council on February 13th and should be used in the formulation of the combined questions for B, C, and D.**

    There is no discrepancy between the requirements necessary for code verification of PWC bases as No Power Option, Single Power Option or Multiple Power Option

through the PDAC and the description of these same "options" through the DME MACs.

Into what power options base category (no power option, single power option or multiple power option) would each of the following configurations fall based on coding guidelines published by the PDAC and the DME MAC? Note the PDAC and DME coding guidelines differ.

a. Power elevating foot platform (1 actuator)
b. Power elevating leg-rests (2 actuators)
c. Power tilt (1 actuator) and a power elevating foot platform (1 actuator)
d. Power recline (1 actuator) and power elevating leg-rests (2 actuators)
e. Power seat elevation (1 actuator), non-covered
f. Power standing system (1 actuator), non-covered Power Options Definition:

PMD LCD PA: Tilt, recline, elevating leg-rests, seat elevators, or standing systems that may be added to a PWC to accommodate a beneficiary's specific need for seating assistance.

PDAC Coding: Tilt, recline, elevating leg-rests, seat elevators, or standing systems that may be added to a PWC to accommodate a patient's specific need for seating assistance.

No Power Option Definition
PMD LCD PA: A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating leg-rests, it is considered to be a No Power Option chair.

PDAC Coding: A category of PWCs that is incapable of accommodating any power options.

Single Power Option Definition:

PMD LCD PA: A category of PWCs with the capability to accept and operate a power tilt or power recline or power standing or, for Groups 3, 4, and 5, a power seat elevation system, but not a combination power tilt and recline seating system. It may be able to accommodate power elevating leg-rests, seat elevator, and/or standing system in combination with a power tilt or power recline. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

PDAC Coding: A category of PWCs with the capability to accept and operate only one power option at a time on the base. A PMD does not have to be able to accommodate all features to qualify for this code. For example, a power wheelchair that can only accommodate a power tilt could qualify for this code.

Multiple Power Option Definition
PMD LCD PA: A category of PWCs with the capability to accept and operate a combination power tilt and recline seating system. It may also be able to accommodate power elevating leg-rests, a power seat elevator, and/or a power standing system. A PWC does not have to accommodate all features to qualify for this code.

PDAC Coding: A category of PWC with the capability to accept and operate more than one power option at a time on the base. A PWC does not have to accommodate all features from

the defined list of power options to qualify for this code, but must be capable of having more than one power feature present and operational on the PWC at the same time.

We would like to work with the DME MACs to revise the policy language such that it

a. **accurately defines "power options" and power seating technology;**
b. **accurately reflects the electrical connections & components to operate power options; and,**
c. **redefines the application of non-covered power options.**

Would the DME MACs support a revision of the PMD LCD and Policy Article? If so, do the Councils need to follow the LCD reconsideration process to accomplish this?

Response: Manufacturers are welcome to submit an LCD reconsideration request to the DME MACs. Information on submitting a reconsideration request is available on each DME MACs web site.

Ostomy/Urological/Medical Supplies

15. **There are allowances in the urological medical policy to properly identify a coude tipped intermittent catheter (A4351 straight tipped vs. A4352 coude tipped). When a coude tipped catheter is medically necessary as a part of a sterile intermittent cath kit, how should the supplier identify the coude catheter so that the more expensive catheter can be reimbursed properly?**

    Response: When a coude tipped intermittent catheter is provided as part of a kit the appropriate code is A4353. When the item is not provided as part of a kit, codes A4352 or A4351 (whichever is applicable) must be billed.

16. **Are there any allowances for provision of A4353 for long term urologic supply customers with a diagnosis of neurogenic bladder who have a history of recurrent UTIs and early symptoms of UTIs in the previous 12 months but don't meet the "AND concurrent presence of one or more of the following signs, symptoms or laboratory findings…"?**

    Response: No.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

17. **Face to Face Documentation: Will the following scenario suffice for the face-to-face documentation requirements: Customer sees physician for follow up after a stroke. The physician writes in the chart notes their discussion regarding the stroke and the effects of the stroke on the beneficiary, but nothing is mentioned regarding any DME. Two weeks later, the beneficiary contacts the physician regarding issues they are having while sleeping and the MD orders the beneficiary a semi-electric hospital bed. Would the**

WOPD sent to the DME supplier for that bed along with the chart notes from two weeks ago that do not mention anything about DME but does mention the stroke and the beneficiary's' condition related to the stroke suffice for the documentation requirements?

Response: Likely not; however, whether the first visit can qualify for the required ACA visit depends upon whether the issue/conditions documented are directly related to the medical condition(s) that justify the need for the ordered DME. The basic bed coverage criterion is that the patient requires repositioning in order to relieve pain, etc. All stroke patients do not need repositioning but some may depending upon the specific manifestations of the stroke. This example suggests that the supplier believes that simply the diagnosis of stroke is a covered justification for a hospital bed. It is not. To comply with the ACA face-to-face requirement, the requirement is that the visit documentation be able to be clearly connect the item prescribed to the item's coverage requirement(s).

18. **When a Home Health Agency begins a covered plan of care is the agency required to inform the beneficiary of the complete list of items it must provide?**

Response: No. The HHA is responsible however to provide any items included on the consolidated billing list that the beneficiary needs regardless of the plan of care during the coved home health episode.

19. **We would like to clarify the formats in which the WOPD date stamp is allowed. Upon calling the CSR at each of the four jurisdictions – here is what we were told:**

Region A = Anne Ref# 1-V7ST62 Stamp, Faxed Received or handwritten and initialed by person receiving WOPD
Region B = Christy Stamp, Faxed Received or handwritten and initialed by person receiving WOPD
Region C = Carolyn Ref #203 Stamp, or Faxed received cannot be handwritten
Region D = Ben Ref # 5275065 Stamp, Faxed Received or handwritten and initialed by person receiving WOPD

It appears that Jurisdiction C is giving a different response than that of the other jurisdictions. We are not sure if this was a simple oversight from the CSR or an actual difference in the requirements. Is it possible, to obtain a uniform response to the approved WOPD stamp allowed formats?

Response: Please refer to the DMD Joint Article published on October 30, 2014, which says in part:

> The DME MACs do not specify what method may be used to indicate date of receipt; however, there must be some indicator or notation on the documents that they were received by the supplier within the required time period. Some commonly accepted methods are hard-copy date stamps, hand-written dates, facsimile headers and electronic receipt dates. Regardless of the method used, it must be clear to contractor staff reviewing the claim that the date received meets the requirements in the applicable LCD.

A cautionary note about utilizing facsimile headers to document receipt date. Suppliers often rely on a fax header that includes a date and time indicator as an alternative to a date stamp. However, there are often multiple facsimile header lines that are the result of documents being faxed back and forth between the supplier and treating physician. Consequently, it is often difficult to determine the actual date of receipt of the documents by the supplier.

20. **Can an ABN be used for a charged upgrade of an item within the same HCPCS code?**

In the CMS Manual Transmittal 2480 Change Request 7821 Dated Jun1, 2012 (page 22 of 32) sited below states the upgrade must be for items with a different HCPCS Code, but in the Medicare Claims Processing Manual-Chapter 20 Section 120 (pg 65 of 98) under A. General Instructions for the Use of ABNs for Upgrading DMEPOS Items….#1 states that an upgrade may be from one item to another within a single HCPCS code.

50.8 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers must give an ABN *before a beneficiary receives a Medicare covered item containing upgrade components that are not medically reasonable and necessary and not paid for by the supplier.* For example, an ABN must be issued when a notifier expects *that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary. DME upgrades involve situations in which the upgraded item or component has a different Heath Insurance Common Procedure Coding System (HCPCS) code than the item that will be covered by Medicare. Please refer to Chapter 20, Section 120 in this manual for information on billing procedures for ABN upgrades.*

ABNs cannot be used to charge beneficiaries for premium quality services described as "excess components." Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being "better" or "higher quality" on an ABN *but do not exceed the HCPCS code description.*

120 - DME MACs – Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades

(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)

A. General Instructions for the Use of ABNs for Upgrading DMEPOS Items

1. An upgrade may be from one item to another within a single Heath Insurance Common Procedure Coding System (HCPCS) code, or may be from one HCPCS code to another. When an upgrade is within a single code the upgraded item must include features that exceed the official code descriptor for that item.

Response: Upgrades could be within the same code, but you must first consider the definition of the code and what features and functions are defined within that code. Many have broad descriptions and therefore are considered all-inclusive. What may appear to be an extra, deluxe or upgradable feature is included in the definition of the code. Take for examples: E0601 – Continuous Positive Airway Pressure Device. An auto-titrating CPAP does not go above the definition of the code and therefore is

not considered an upgrade. The L8000 – Breast Prosthesis, Mastectomy Bra, without integrated breast prosthesis form, any size, **any type** is another example. A difference in cost between two items is NOT a justification for an upgrade.

CEDI

No questions submitted

PDAC

21. **ProBasics Economy Wheelchair EC09 is coded by the PDAC as a K0006 (Hvy Duty Wheelchair for patients over 250lbs). This chair has a weight capacity of up to 300 lbs, but is commonly used for patients under 250 lbs. Could the supplier also bill this chair as a K0001 or would an ABN upgrade be required? Can the manufacturer request a dual code (K0001 and K0006)?**

    Response: There are two options:

    1. If the beneficiary weights over 250 lbs and meets the requirements in the manual wheelchairs LCD for coverage, the supplier must use HCPCS code K0006.

    2. If, for the supplier's convenience, they wish to provide this chair for a patient under 250 lbs (i.e., not medically necessary), the supplier may bill the chair as an upgrade using the appropriate modifiers.