National Government Services

Medicare

National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

Jurisdiction B Council A-Team Questions
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Home Medical Equipment

1. The March 2009 notification of prepayment review for NPWT indicates medical records must document the "wound measurements approximately one month prior to initiation of NPWT." The Local Coverage Determination (LCD) indicates the patient must have a chronic Stage III or IV pressure ulcer, neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology but does not indicate the provider must have documentation of the wound measurements 30 days before the NPWT is applied. Please advise.

   ANSWER: For Negative Pressure Wound Therapy (NPWT) initiated on wounds in the home setting, the LCD indicates that the treatment is for "chronic" wounds. Chronic is defined in the LCD as "being present for at least 30 days". Documentation of the wound characteristics 30 days prior to initiation of treatment is needed to establish the chronicity of the wound and whether it is responding to the various conservative treatment measures outlined in the policy.

Enteral/Parentral/IV Therapy

No questions submitted

Respiratory Care Equipment/Oxygen Therapy

2. Patient received a BiPAP in March 2008, under the old rules. Patient and physician were both sent the compliance letters and the physician returned his letter stating patient was using at least 4 hours per day and benefiting from it. The patient will not sign because he is NOT using. He also refuses to return the machine. At setup we did not have an Advance Beneficiary Notice (ABN) signed. We have tried to get him to sign an ABN now since he is not using and does not want to return. He no longer qualifies in my opinion and refuses to sign the ABN or return the equipment. If I bill Medicare without the KX and GA modifiers I will receive a contractual denial. How can I legally go about getting our equipment back in Medicare's eyes? Since he is not using he does not qualify – can I send him a bill without going through Medicare?

   ANSWER: If the beneficiary is non-compliant in use of the BiPAP device and refuses to sign an ABN accepting financial liability or refuses to return the equipment suppliers have two choices.

The supplier can legally pick-up their equipment if the beneficiary refuses to accept financial liability for the equipment that is no longer medically necessary. If the supplier accepts assignment and expects a denial on the basis that the item does not meet medical necessity, completes the ABN, and advises the beneficiary that Medicare denial is expected, but the beneficiary refuses to sign the ABN, the supplier may annotate on the ABN that the beneficiary refused to sign, have it witnessed, and then submit the claim with the GA modifier. Because the supplier issued the ABN, annotated it, and had it witnessed, the supplier may submit the claim with the GA modifier. In this situation, Medicare will assign financial liability to the beneficiary. These instructions can be found in the Internet Only Manual (IOM), CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 40.3.4.6(A).

This situation sometimes occurs when the beneficiary does not agree with the supplier's determination that the item is not medically necessary, but the supplier believes that it could put the beneficiary's health at risk to not provide the item – or perhaps the beneficiary is a long-standing customer and the supplier does not want to jeopardize the relationship, believing the beneficiary will pay when he/she receives the denial from Medicare. This situation should be rare.

3. Private insurance purchases a Positive Airway Pressure (PAP) device for a patient who is now enrolled in FFS Medicare. Patient needs new PAP supplies but has not followed up with physician since enrolling in FFS Medicare. Can we dispense supplies to patient, hold the claim and then submit the claim once they follow-up with the physician? If a patient has been using a PAP device regularly and the mask breaks, the patient can't wait for doctor visit to replace mask. Will Medicare cover the mask in these situations?

   ANSWER: In that situation, if the required evaluation by the physician is performed in a reasonable period of time after delivering the supplies, the supplies can be covered. However, the supplier may not add a KX modifier to the claim until after the evaluation has occurred. Refer to the Positive Airway Pressure Devices LCD, Beneficiaries Entering Medicare section, for additional information at: www.NGSMedicare.com.

4. **A.)** Private Insurance purchases PAP device for patient who is now enrolled in FFS Medicare. They have a qualified sleep test and have had the clinical evaluation that documents diagnosis of sleep apnea and that they continue to use PAP device. Patient needs replacement machine – do we have to have a download and face-to-face evaluation between day 31 and 90 for the set-up of the replacement machine?

B.) Medicare FFS purchased machine for patient, but patient needs replacement machine – do we need download and face –to-face between day 31 and 90 of the new machine?

ANSWER: For any replacement PAP device, whether the prior device was obtained while the beneficiary was in FFS Medicare or prior to Medicare FFS enrollment, there is no requirement for a physician re-evaluation or objective documentation of compliance in order to cover the fourth and subsequent months of use of the replacement device. However, a physician evaluation is required prior to providing a replacement device which documents that the beneficiary continues to use the device.

5. When a beneficiary fails the initial 12-week trial for a PAP device, the guidelines state to be eligible to re-qualify there must be both a face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and repeat sleep test in a facility-based setting (Type 1 study). If the original test was a Type 1 study, can the repeat sleep test be a titration study only?

   ANSWER: No, the repeat study cannot be solely a titration study. It could be a split night study, but it must include a valid diagnostic study with the patient not using a PAP device.

6. In a listserve dated 6/4/09 from National Government Service regarding CO-96 denials for replacement oxygen equipment the following reason was cited: ***Claims for subsequent months were billed prior to the new initial CMN being set up in the DME MAC claim payment system.*** We had in fact attempted to transmit the appropriate CMN but it was denied on the front end transmission reports, which therefore forcing us into appeals to get the new CMN established. How can this be something that is under the provider's control?

   ANSWER: When suppliers submit the first month's rental claim for replacement oxygen they must append the RA modifier and include a narrative indicating RUL and the date the patient obtained the original oxygen equipment. Suppliers will receive a front end transmission report from CEDI indicating the new CMN was rejected. However, the CMN is transmitted and pended for claims processors to utilize. When the claim with the RA modifier comes into the claims processing system it is pended and prompts the claim processors to look into the claims processing system for the pending initial CMN that was transmitted with the claim. The processors are then instructed to set up the new CMN to allow payment. However, it has come to our attention that some claim processing errors have occurred resulting in CO-96 denials. Claims processing staff have been made aware of these issues and additional training was provided to claims processors in early June.

7. There seems to be some conflicting information regarding traveling oxygen patients. Please clarify the supplier's responsibility for leisure travel during months 1-36 prior to the end of the oxygen cap and also months 37-60 after the oxygen cap has been met. Clarification is also needed on portable concentrators. If the beneficiary's provider does not carry portable concentrators can the beneficiary go to another provider and pay cash for the equipment if that is what they choose for their convenience?

   ANSWER: Suppliers who bill for oxygen during the first 36 months must provide or arrange for oxygen to be provided to the beneficiary who travels for the entirety of each month they receive payment. Medicare will pay only one supplier to provide oxygen during any one rental month. If the beneficiary travels and they are still outside the home supplier's service area on the billing/anniversary date, the home supplier is encouraged to either provide or arrange for the oxygen itself or assist the beneficiary in finding a temporary supplier (billing) in the new location. If the home supplier decides to continue to provide oxygen to the patient while they are traveling or if the home supplier arranges for another supplier who does not bill Medicare to provide the oxygen, the home supplier bills for whatever system the patient is using on the anniversary/billing date.

   The supplier may provide the patient with different oxygen equipment (e.g., portable concentrator) for travel, if there is an order from the physician. The home supplier may not bill for or be reimbursed by Medicare if it is not providing oxygen or has not arranged for a temporary supplier (non-billing) to provide the oxygen on the anniversary billing date.

   If a supplier provides oxygen during the 36th rental month and the beneficiary travels or relocates that supplier is required to provide oxygen to the patient either directly or the supplier may make arrangements with another supplier to supply oxygen and oxygen service to the beneficiary while they are outside the supplier's service area. Neither supplier would submit a claim for oxygen because the supplier who received payment for the 36th rental month is required to continue to provide oxygen after the 36 month cap until the 5 year RUL is met.

   If a beneficiary travels or relocates, the supplier could provide the patient with different oxygen equipment (e.g., portable concentrator), if there is an order from the physician. The supplier would not submit a claim for that equipment (because it is required to continue to provide equipment after the 36 month cap). The supplier is responsible for mailing replacement supplies (tubing, cannulas, etc.) to the beneficiary or making other arrangements for the furnishing of these supplies. The supplier is responsible for any maintenance and servicing required and can make arrangements with another supplier for furnishing these services.

If the supplier who furnished oxygen during the 36th rental payment does not carry portable concentrators and the beneficiary does not want to accept the equipment the supplier offers during travel or does not want to utilize the arranged services of a supplier in the area they are traveling to solely due to their own choice or convenience the beneficiary may opt to go to another provider and pay cash for the equipment. The existing supplier is under no obligation to reimburse the beneficiary for oxygen received outside of the servicing area when the existing supplier did not make the arrangements. Oxygen suppliers are responsible for furnishing medically necessary oxygen equipment, services and supplies. Oxygen suppliers are not required to provide specific types of oxygen equipment because the beneficiary requests them for convenience (i.e., portable concentrators). Suppliers are encouraged to explain to the Medicare beneficiary the new payment policy for oxygen and oxygen equipment and that Medicare will not reimburse them for oxygen equipment that they purchase.

8. In the revised LCD in June that was effective **01/01/09** there's a new requirement for oxygen patients who were tested while exercising. The policy was previously silent about the timing of all three required tests, although it was generally understood that they should be taken at the same time or close to the same time. Now the policy says all tests must be taken during the "same testing session."

   One issue is that many physicians don't have oxygen in their offices. So they can take the two room air tests but can't take the 3rd test on oxygen and have to send the patients to a hospital or other facility to be tested on oxygen and that won't be immediate or in the "same testing session." Additionally, only the test while exercising on room air goes on the CMN so the CMN we transmit will appear to qualify the patient. But, if the patient didn't have the 3 tests or they weren't taken at the same time, the patient really doesn't qualify. So, how does the provider tell Medicare the patient doesn't qualify? We'll want to get ABNs and bill the patient but I can see Medicare paying based on the CMN. I'm actually surprised they didn't slap a KX modifier requirement on us.

   ANSWER: Although not explicitly stated, the interpretation of the policy has always been that all 3 tests need to be performed within the same session. It is particularly important to see that the level of exertion that resulted in the desaturation can be corrected by the administration of oxygen. If the first two steps were performed as a screening test in a facility that does not have access to oxygen, then they will need to be repeated immediately prior to the trial with oxygen.

   There currently is no automated way for the supplier to indicate that the testing requirements were not met. If they were not met, and the claim paid, the supplier should submit a voluntary overpayment refund. When sending in a refund, use the Jurisdiction B DME MAC refund form, which can be found in Chapter 21 of the

Jurisdiction B DME MAC Supplier Manual, on the Jurisdiction B DME MAC Web site at www.NGSMedicare.com.

9. **Follow-up from May 2009 Q & A:** The Jurisdiction B Listserv dated 1/27/09 states "you must also have proof of delivery documentation in your files for the item being replaced that documents that the oxygen equipment has been in use for at least five years." In many situations, a patient switches companies and the previous supplier is unable or unwilling to provide the original delivery ticket that shows the patient has been on oxygen equipment for five years. Medicare has this information in the form of the Initial CMN date and the number of months billed and paid. Isn't this information sufficient enough to show that the equipment has been in use for five years? **Answer:** Current instructions from the Centers for Medicare & Medicaid Services state that the supplier must have proof of delivery documentation on file for the item being replaced; however, Medicare contractors are aware that there are situations in which a supplier may not have access to proof of delivery documentation, such as when the supplier that delivered the original equipment has gone out of business or does not/will not provide the requested proof of delivery documentation. Therefore, we are seeking CMS guidance regarding how to handle documentation requirements for replacement of oxygen when a supplier is unable to obtain the required proof of delivery. **Is there a response from CMS on this issue for it impacts all providers?**

   ANSWER: The answer referenced above from the May council meeting has been revised to reflect the following:

   National Government Services is aware that there are situations in which a supplier may not have access to proof of delivery documentation, therefore National Government Services is currently seeking clarification from CMS, as well as, formal instructions before educating the supplier community on this issue.

   Currently, National Government Services is still waiting for formal instructions regarding this issue from CMS.

Prosthetics/Orthotics

10. Elastic Garments (L0210, L1800, L1815, L1825, L1901, L3651, L3652, L3700, L3701, L3909, and L3911) will be denied as non-covered effective April 1, 2009, no benefit category. When reviewing these codes on the HCPC Code Listing on the National Government Services Web site and the CMS Web site, it still has these HCPC codes listed as a coverage code C (carrier judgment). Since they are listed as a coverage code C, are we required to obtain an ABN? Will these codes be changed to coverage code M (non-covered by Medicare) where we do not need to obtain an ABN?

ANSWER: The Centers for Medicare & Medicaid Services (CMS) has determined that elastic garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Therefore, effective for claims with dates of service on or after April 1, 2009, these items will be denied as statutorily noncovered, due to not meeting a benefit category. An ABN is not required for statutorily noncovered items. However, suppliers can execute an ABN as a voluntary notice to the beneficiary. Suppliers should refer Durable Medical Equipment Coding System (DMECS) on the Pricing Data Analysis Contractor Web site for coding instructions at: https://www.dmepdac.com/dmecs/index.html

Rehab Equipment

11. The DMEPOS quality standards specify that for Complex Rehab Wheelchairs the supplier shall employ a qualified RTS/ATP per location. The RTS shall have at least one or more factory trained technician available to provide service. If a supplier dispensed a power chair with power tilt prior to the ATP requirement for complex rehab and the provider does not currently have an ATP on staff, can the provider make repairs to the power tilt? Based on the DMEPOS quality standards does the ATP requirement extend to suppliers for the repairs of complex rehab wheelchairs and the repair and replacement of complex rehab options, accessories, and seating, etc.?

    ANSWER: The requirements in the DMEPOS Quality Standards for Complex Rehabilitative Wheelchairs and Assistive Technology do apply to repair and replacement of accessories for these wheelchairs. Therefore, a supplier who did not have a Rehabilitative Technology Supplier (RTS) and trained technician on staff would be in violation of the Quality Standards if they repaired a power tilt seating system.

12. When is it appropriate to perform the required home evaluations for Power Mobility Devices? Can the home evaluation take place before the detailed product description (DPD) is written, signed, dated and returned to the supplier?

    In many instances the home evaluation takes place prior to the time when the DPD is generated in order to determine the appropriate wheelchair and accessories and confirm the recommended product is able to be utilized in the home. This is especially true when there is no medical contraindication to use a POV as the home evaluation will confirm or rule out whether a POV can be used safely and effectively in the home prior to submitting the DPD to the physician.

    Please confirm when it is appropriate to perform the required home evaluation.

    ANSWER: The home assessment must be performed after the supplier receives the 7-element order and the report of the face-to-face examination and before or at the

time of delivery. However, it may be performed prior to completion of the detailed product description.

13. Please provide clarification on what goes in the narrative field for miscellaneous codes on initial or serviced equipment. Does the HCPCS code, serial number, or both have to be in the narrative field? If the HCPCS codes have changed which HCPCS code would be applicable for the base equipment, the original HCPCS code which was in effect at the time the item was originally dispensed or the current HCPCS code? Is the serial number, purchase date or manufacturer required in the narrative field for any HCPCS code billed with the base?

    ANSWER: When suppliers bill for miscellaneous, not otherwise classified (NOC) HCPCS codes initially or as part of a repair, the following must be included in the NTE segment of the electronic claim or in item 19 for paper claim submission:

    - **a narrative description of the item,**
    - **the manufacturer, brand name and model name/number of the item if applicable and**
    - **a statement indicating what base equipment the item is being used with and why the item is medically necessary for the patient.**

    Suppliers should also include the date the base equipment was obtained by the beneficiary if they have reason to believe that the base equipment was not paid for by Medicare Fee-for-Service. Please refer to the individual local coverage determinations for additional information on what information is needed to support medical necessity of NOC codes.

Ostomy/Urological/Medical Supplies

No questions submitted

Diabetic Monitoring and Supplies

No questions submitted

Documentation/Regulatory/Miscellaneous/Other

14. This is a Negative Pressure Wound Pressure Therapy question. The LCD for Negative Pressure Wound Pressure Therapy (NPWT) does not specify the required depth of the wounds or ulcers. There is, however, a bulletin 20070426-E2402 which states 51% of the claims were denied because the medical information submitted did not demonstrate that the policy criteria were met. One of the issues was: wound depth less than 0.5cm is not indicative of full thickness skin loss. What is the depth requirement for NWPT? Is there additional documentation to help support this requirement? Does the depth requirement apply to all wounds and ulcers mentioned in the LCD?

ANSWER: All of the wound measurements, length, width, and depth and the extent of tunneling or undermining, if present, are important in the determination of medical necessity for an NPWT pump at the time of individual review of a claim. Wound measurements may indicate a wound whose small size doesn't justify initial use of a pump. Also, since a NPWT pump does not have to be used until the wound is completely healed, serial measurements provide some of the evidence needed to decide when a pump is no longer needed. A depth of 0.5 cm is not used as an absolute determinant of coverage. Other elements of consideration include the location of a wound. A 0.5 cm wound in the thin skin over a bony prominence – e.g., ankle – is more significant than a 0.5 cm wound on a buttocks. It is not possible to state in the LCD all of the possible combinations of factors that are involved in determining the medical necessity for an NPWT pump.

15. At one of the recent '201' workshops, there was a discussion about ABNs and retro-active Medicare eligibility. If a customer was not eligible for Medicare at the time an item was delivered, but then receives retroactive eligibility, the provider will usually not have the documentation required by Medicare to file a claim. At the workshop, it was stated that an ABN could be offered/signed at the time the provider finds out about the Medicare eligibility; or, alternatively, that ABNs could be offered to all non-Medicare customers with 'lack of necessary medical documentation in case the non-Medicare customer becomes retroactively eligible for Medicare' as a reason for possible denial. Neither of these options 'feels' right: the first because it is after the fact, and the second because this seems like a blanket ABN. Please discuss ABN options for a customer who is retro-actively eligible for Medicare after a service is provided.

    ANSWER: The ABN applies only to patient's currently enrolled in the Medicare Fee-for-Service program. Suppliers should not issue an ABN to patient's who are not yet entitled to Medicare benefits "just in case" they become entitled to Medicare retroactively.

    If a DMEPOS item is delivered to a patient who is not entitled to Medicare, but subsequently becomes entitled to Medicare with a retroactive effective date that covers the date of service in which the item was delivered (or the period of rental), at the time the supplier is informed of the beneficiary's Medicare entitlement, the supplier should obtain a copy of the entitlement letter issued by Social Security or annotate the beneficiary's records and have the beneficiary sign and date the annotation. Also, the supplier must determine if the beneficiary meets medical necessity for the item according to the coverage criteria outlined in the Local Coverage Determination (LCD). If the beneficiary does not meet medical necessity for the item per LCD guidelines, the supplier must issue an ABN, ensuring that the beneficiary signs and dates the ABN. The ABN is considered effective with the

date it is delivered (the date the beneficiary has read and understands). If the beneficiary elects to have a claim submitted to Medicare for a determination, the supplier may append the GA modifier to the HCPCS line of the item beginning with service dates on or after the date that the beneficiary has signed ABN.

Clarification regarding beneficiaries who are granted retroactive Medicare benefits was provided in November 2007. For additional information please refer to the CMS IOM, Pub. 100-05, Medicare Secondary Payer (MSP) Manual, Chapter 7 – Contractor MSP Recovery Rules, Section 20.5, CMS IOM Pub. 100-05 Medicare Claims Processing Manual, Chapter 1-General Billing Requirements Section 70.7.1, and Administrative Errors and Transmittal AB-02-114/Change Request 2219.