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

1. Does Medicare cover breast pumps (E0603) for disabled women who are of childbearing age?

   Breast pumps (electric or manual) are not covered under Medicare guidelines because they do not meet the definition of durable medical equipment (DME). For additional information, see the Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-2, *Medicare Benefit Policy Manual,* Chapter 15, Section 110.1.

2. Does Medicare require a new physician's order if a patient is renting a hospital bed with mattress (E0260) but then is switched to a hospital bed without mattress (E0261) because the patient's condition has worsened and they now require a low air loss mattress?

   The Centers for Medicare & Medicaid (CMS) Internet-Only Manual (IOM) IOM Publication 100-8, *Medicare Program Integrity Manual,* Chapter 5, Section 5.2.4 states that a new order is required when there is a change in the order for accessory, supply, drug etc. In this situation if the physician originally prescribed a semi-electric hospital bed with mattress (E0260) and the patient's condition changed which resulted in the patient now requiring a hospital bed without mattress (E0261) a new order would be required.

   Suppliers are reminded that the written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. "Sufficiently detailed" has been interpreted by the DMDs to mean, that the description needs to be specific enough for the DME MACs to know that the HCPCS code billed is appropriate for the item ordered.

Enteral/Parenteral/Infusion (IV) Therapy

3. A patient has a chest catheter with port implanted by a physician. The physician orders a vacuum drainage bottle and tubing for use with implanted catheter (A7043), is this covered by the DME MAC and if so how should it be billed. We have been unable to get the claim through the front end edits, we have tried with a KX modifier, without modifiers, etc. What are the coverage criteria, documentation requirements and quantity limits for A7043?

   According to the 2011 Jurisdiction List for DMEPOS items, Health Care Common Procedure Coding System (HCPCS) code A7043 should not be submitted to the durable medical equipment Medicare administrative contractor (DME MAC). This code should be submitted to the local Part B Carrier or AB MAC.

4. From the fall MedTrade meeting with Noridian Administrative Services (NAS): "Also, there were several questions regarding the changes to "Refill Requirements", in what exactly is required when we contact the beneficiary for current inventory on hand…what must be asked? Dr. Whitten indicated that for every HCPCS code that is billed to Medicare, we need to have asked if the beneficiary's supply is close to being exhausted by the end of the usage period prior to sending additional quantities. (I am not sure of the exact comment made here although it was not my impression that we needed to have an exact count of every item)".

   When asked about the retail environment – Dr. Whitten did agree that by default, the beneficiary is coming into the retail store which documents "beneficiary is requesting a refill", and then leaves with an invoice for the items refilled which documents proof of delivery. Both required documentation elements are met in the same occurrence.

   Please further clarify:

   a. When billing for items that are included in a daily "kit" code, e.g., enteral supply kits, total parenteral nutrition supply kits, and external infusion supply kits, we do not necessarily ask the beneficiary to count each one of the ancillary items that are included in the "kit" but rather determine when we are obtaining "current inventory on hand" they have adequate supplies to administer their therapy through the end of the current usage cycle. For the refill, we would determine, based on therapy protocols and safe administration, what needs to be sent for the next usage cycle. This can vary for each patient depending on what type of IV access they have (flushes), what type of feeding tube they have (extensions, gauze, tape, etc.) and what method of administration (pump sets, bags, cassettes, etc.). None of these supplies are billed outside the "kit" HCPCS code and are reimbursed as a liter per each day of administration. While each ancillary is listed on the delivery ticket individually, our documentation of contact with the beneficiary for refill request would not be listed individually. We want to know if this is

acceptable and meets the documentation requirements for supplies provided on a reoccurring basis. There has been concern in the industry that during audits, it may not be considered as compliant for meeting, "quantity of each item that the beneficiary still has remaining".

The "kit" HCPCS code is all-inclusive and billing of individual components is considered unbundling. There is no need to count the number of individual kit components, only the number of kits remaining.

b. The second part of this question pertains to detailed written orders (DWOs) and the same situation, if each ancillary items that is included in the daily administration "kit" must be listed individually on the detailed written order, or if a statement such as "all cassettes/bags and supplies necessary for administration" or enteral gravity/bolus/pump supply kit" will be considered detailed? In other words, we are using a description of the HCPCS code vs. itemizing everything that may be included in that HCPCS code.

The detailed written order (DWO) does not need to list each item in the kit since the items are billed using a kit HCPCS code.

5. The following question was asked regarding detailed written orders (DWOs) for statutorily non covered IV therapy. Again with the interpretation being different amount the four DME MACs , it makes it difficult for suppliers to figure out the correct way to bill.

a. In regard to home infusion therapy for IV anti-infectives NOT delivered via an external infusion pump, which are statutorily non-covered, (i.e. there is no defined Medicare benefit), we must bill for denial in order to move to the beneficiary's secondary payer. We are instructed to use the GY modifier in this situation to produce a patient responsibility (PR) denial. Most state pharmacy board rules and regulations, allow us to dispense based on a verbal order given to a licensed pharmacist. Often, the verbal is accompanied by a written order on Rx script, but it may not necessarily meet all the requirements of a "detailed written order" as defined by Medicare.

Here is an example:

Receive RX script for IV Cubicin 500 mg q 12 hours X 6 weeks via PICC; signed and dated by the physician.

Drug is not covered under the DMEMAC benefit as delivered via elastomeric device or other disposable device that is NOT considered "durable medical equipment". The written script received does not contain specific language for supplies or administration device (A4223 or A4305).

Must we bill with the EY modifier?

No. You would bill with the GY modifier. You do have a physician order even if it is incomplete.

It would seem to us that the EY modifier would not be required in this situation of "statutorily non-covered therapy" since Medicare has no jurisdiction over non DMEPOS services. However, if the direction is that we must use the EY modifier when we do not have a complete detailed written order, would we get a PR denial vs. a CO denial? In order to move to the secondary payor, we need to show patient responsibility.

No. You would bill with the GY modifier. You do have a physician order even if it is incomplete.

Respiratory Care Equipment/Oxygen Therapy

6. When the beneficiary fails the 12 week trial, can the face-to-face clinical re-evaluation to determine etiology of failure to respond to positive airway pressure (PAP) therapy take place after the repeat sleep study?

When a beneficiary fails the 12 week trial the policy requires a repeat type I sleep study and a clinical re-evaluation by the treating physician. It is not required that the re-evaluation take place prior to the sleep study but in order to bill for the 4th and subsequent months with the KX modifier both of these requirements must be met.

7. We have some physicians questioning the need for an existing oxygen patient who becomes FFS Medicare eligible and their need for a face-to-face visit with their physician. The policy states it in a roundabout way, but you have to look several places to come up with this conclusion. Is there anything anywhere that spells this requirement out so we can share with the physicians? Could it be added to the Dear Physician letter for oxygen and the oxygen checklist on the website?

Yes, there must be an in-person visit with the provider. The LCD states that an initial Certificate of Medical Necessity (CMN) is required with the first claim for home oxygen, even if the patient was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO. The LCD goes on to state under the "Testing and Visit Requirements" section of the LCD that the patient must be seen and evaluated by the treating physician within 30 days prior to the date of initial Certification. The DMDs will consider adding this language to the Dear Physician letter.

8. The recent revision to the requirements for refills states that the documented refill request must contain the beneficiary's name (or authorized representative), a description of the item requested,

date of refill request, and quantity of item remaining. For patients receiving liquid oxygen refills, would all of these requirements still apply? In the case of liquid oxygen refills, the delivery is made as part of a regular route, and the patient often does not know the quantity remaining. If all of these requirements still apply would "I'm sure I need some" or "low" or "around half" or "kinda full" be satisfactory descriptions of quantity remaining?

The following requirements outlined in the Local Coverage Determination for Oxygen and Oxygen Equipment apply equally to requests for refills of liquid and gaseous oxygen contents.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- **Beneficiary's name or authorized representative if different than the beneficiary**
- **A description of each item that is being requested**
- **Date of refill request**
- **Quantity of each item that the beneficiary still has remaining**

National Government Services is aware that it is sometimes difficult for a beneficiary to determine the exact amount of oxygen contents they have remaining; therefore, a beneficiary's statement of "I'm sure I need some," "low," or "around half" are satisfactory descriptions to indicate the quantity remaining.

For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

9. For regular portable oxygen deliveries, we currently call the patient the day before to determine the number of cylinders to be delivered. Would the CSR's call log be sufficient documentation if it indicated the number of cylinders requested?

According to the refill requirements outlined in the Local Coverage Determination for Oxygen and Oxygen Equipment, a proper request for refill for contents that are delivered to the beneficiary includes:

- **Beneficiary's name or authorized representative if different than the beneficiary**
- **A description of each item that is being requested**
- **Date of refill request**
- **Quantity of each item that the beneficiary still has remaining**

The customer service representatives (CSR) log must include all the above listed items, including the quantity of each item that the beneficiary still has remaining. An indication of the number of cylinders requested does not satisfy the requirement of documenting the quantity of each item that the beneficiary still has remaining.

Prosthetics/Orthotics

10. If a supplier is billing for mastectomy bras (L8000) and the physician indicates on the detailed written order, "lifetime need"; will this be acceptable in an audit or do we need a new detailed written order each year?

A prescription/order is valid for the time period the doctor prescribes, i.e., one month, six months, 12 months, or lifetime, unless a state or federal law requires a new prescription/order or policy specifies a specific time when a new order is required.

11. Is there ever an instance where a supplier could bill for an upgraded mastectomy bra? There are so many different styles and costs available, can an upgrade be allowed when the bra is more expensive due to the type of fabric such as lace, rather than plain cotton?

No. The CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 20, Section 120 describes an upgrade as "an item with features that go beyond what is medically necessary. An upgrade may include an excess component. An excess component may be an item, feature, or service, which is in addition to, or is more extensive and/or more expensive than the item that is reasonable and necessary under Medicare's coverage requirements."

This chapter goes on to describe the appropriate usage of an Advance Beneficiary Notice of Noncoverage (ABN) in such a setting. A difference in price alone is not justification for an upgrade. Therefore, mastectomy bra healthcare common procedure coding system (HCPCS) codes L8000, L8001, and L8002 may not be upgraded since the definition of the HCPCS code is not limited to a specific type of fabric, style, or cost, but rather, encompasses all fabrics, styles, and costs.

Rehab Equipment

12. A physician orders an ultra-lightweight wheelchair (K0005) and the beneficiary qualifies. However, the beneficiary would like up-graded casters and rear wheels (i.e., high performance). These would be upgrades, but how does the supplier bill for this? Since code K0005 includes standard casters and rear wheels, would this be considered an upgraded base?

No. The supplier must meet correct coding guidelines. All wheels regardless of the type are included in the allowance for the wheelchair base (K0005). Furthermore, casters (E2214, E2219) are generic and would encompass all types of separately billable casters. Therefore, the upgrade provisions do not apply in the scenario provided. For additional information regarding wheelchair options and accessories, suppliers should refer to the wheelchair options and accessories bundling table located in the wheelchair options and accessories policy article.

13. The January 2012 HCPCS code updates changed several codes for Mobile Arm Supports (when used with a wheelchair) from "L" codes to new "E" codes. If we provide a Mobile Arm Support (or related accessory) that is not specifically described under one of these new codes, do we code it as K0108 or as an "L" miscellaneous code?

The proper code to use is K0108, a wheelchair component or accessory, not otherwise specified. This has not changed.

14. If a beneficiary receives a power wheelchair with a power tilt & seat elevator will the code E2311 be covered or only E2310? Per the LCD it reads:

> Codes E2310 and E2311 describe the electronic components that allow the patient to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or nonproportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing.
>
> It is understood that the seat elevator is non-covered, however the manner in which the policy reads, it appears that if a provider were to bill for code E2311 on a power wheelchair with a power tilt & seat elevator it could still be billed and covered (with appropriate medical justification). Please advise.
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> **To restate the question: What if a non-covered power wheelchair option such as a power seat elevator or power standing feature necessitates the use of E2311 instead of E2310? Will E2311 be reimbursed? The answer is no, the addition of non-covered options does not justify the additional payment for components that are required by the non-covered option. Since the E2311 will be considered not reasonable and necessary, it may be billed as an upgrade.**

Ostomy/Urological/Medical Supplies

15. If a supplier is billing for A4353, and the beneficiary meets the medical documentation requirements for recurrent urinary tract infections and the physician writes an order for lifetime, would the original documentation still be adequate to support medical need or would the supplier need to have documentation to support continued use and need?

The original documentation must be substantial for initial coverage criteria. Some documentation from the treating physician regarding the patient's continued use or need must be present, and must be contemporaneous to the date of service.

16. For A6197-A6199, A6209- A6215 and A6251-A6256 does the wound need to be a pressure wound (decubitus ulcer) at stage III or IV with higher levels of exudate for coverage or are there times that a stage II would qualify if the other criteria are met?

No. The Surgical Dressings Policy is not specific to the coverage of dressings for pressure ulcers only. Be mindful of meeting the basic criteria in all circumstances of choice of dressings. For those dressings being questioned here, the language in the policy repeatedly states, when describing the requirements, "moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers)". There are no times that a stage II wound, which is not a full thickness wound by definition, would qualify for coverage for these dressings noted, if the other criterion – of being moderately to highly exudative - is not met. It is required that the wound be full thickness, which in the case of a pressure ulcer only, would be defined as stage III or IV (these are definitions set by the National Pressure Ulcer Advisory Council). Non-pressure ulcer wounds are not required to be measured by the pressure ulcer staging guidelines, but would still need to be full thickness, in addition to being moderately to highly exudative.

17. What are the coverage criteria and medical necessity requirements for A6261 and A6262 Not Otherwise Specified wound fillers? We have billed providing brand names and descriptions of product, wound size, depth, drainage, etc. We have received different denials each time, twice for CO-50 and twice for PR-16. We are providing the information the LCD indicates is required in the NTE, but do not know the coverage requirements. We need this information to execute a proper ABN if nothing else. (The wound fillers they are billing are Iodosorb and Iodoflex)

Wound fillers are covered under the Surgical Dressing Benefit, therefore the coverage and payment rules outlined in the Surgical Dressing Local Coverage Determination and Policy Article must be met.

Surgical dressings are covered when either they are required for the treatment of a wound caused by, or treated by, a surgical procedure; or they are required after debridement of a wound. Furthermore, use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented. It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate). The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change and the recent use of dressings, and surgical dressings must be tailored to the specific needs of the patient.

Please note there are unique codes for other wound fillers, e.g. A6024 (collagen, A6199), A6215 (foam), etc.

1. **Not Otherwise Classified (NOC) coded wound fillers are covered under the same rules as specifically- coded wound fillers, i.e., when a qualifying wound is large (deep) enough to require a filler to close the space and the material of the filler is appropriate to the wound type (e.g. hydrogel on a dry wound or collagen on an exudative wound). The filler chosen must be compatible with the primary dressing as well. For additional information on billing NOC coded surgical dressings (A4649, A6261, A6262, A6512) suppliers should refer to the article "Situations Requiring a Narrative Explanation in Item 19", which can be located on the National Government Services Web site under Resources and Tool and Materials.**

For questions on specific denials, suppliers should contact the National Government Services Provider Contact Center at 1-866-590-6727.

18. Is there a required minimum depth in wound size for wound fillers/packing strips in general. Needed for proper ABN execution as well.

While there is no specified wound depth, the function of a wound filler is to occupy space in a wound that would otherwise be left open when the primary dressing is applied. Since all primary dressings are flexible, they are able to conform to the depth of a shallow wound and fill the space, making the use of fillers not reasonable. When fillers are used, we expect that the wound is of sufficient depth such that the dead space is unable to be filled with the chosen primary dressing, thus making the use of a filler necessary. This information should be reflected in the medical record to justify coverage and be available in the case of an audit. As the wound heals and the depth decreases, filler should be discontinued when the primary dressing is sufficient to fill the dead space.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

19. At the time a beneficiary comes to our facility to purchase a seat lift chair, they typically have only a prescription. They usually want the item delivered as soon as possible, but we do not have enough information to make a determination of coverage. We therefore do not have a specific reason to expect that it will not be covered, so it would be inappropriate to obtain an Advance Beneficiary Notice (ABN). When we receive the CMN and other documentation from the physician's office, it is too late to obtain an ABN if it appears the seat-lift mechanism would not be covered (since an ABN must be obtained before the beneficiary receives the item). A number of years ago we were informed by the DMERC Medical Director that, in this circumstance, it would

be appropriate to obtain an ABN with the reason for expected denial given as "insufficient medical documentation available at time of purchase to make coverage determination." Would this still be a valid reason to obtain an ABN? If not, would it be appropriate to deny service to Medicare beneficiaries (who want a Medicare claim submitted) until the back-up documentation has been received and a "likelihood of coverage" decision made?)

No, the reason cited above would be considered a blanket ABN and would not be valid.

20. These questions arise from the CERT Task Force presentation presented at MedTrade 2011 and at a CERT Task Force Webinar on December 13th.

All the questions regarding the CERT Task Force presentation will be answered in the CERT Task Force question and answer document which is forthcoming.