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

1. We have a referral source asking us to deliver Continuous Passive Motion (CPM) devices prior to the patient having the total knee replacement surgery for pain reasons. The referral source wants to make sure the CPM device is in the patient's home when the patient is discharged from the hospital. The patient will not be using the CPM device during their inpatient hospital stay. The date we deliver the CPM device to the patient's home and the date they start using the CPM device at home will be approximately 5-6 days apart. Would it be appropriate for our company to do this? Would it be appropriate for us to change the date of service on the claim to the date of discharge from the hospital?

ANSWER: No, it would not be appropriate to deliver the CPM device to the patient's home prior to the patient having the total knee replacement surgery, or 5-6 days prior to the patient being discharged from the hospital.

The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual, Publication 100-08, *Medicare Program Integrity Manual,* Chapter 4, Section 4.26.2 clearly states that a supplier may deliver a DMEPOS item to a patient's home in anticipation of a discharge from a hospital or nursing facility. The supplier may arrange for actual delivery of the item approximately <u>two</u> days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and should use the POS code 12 (patient's home).

Enteral/Parentral/IV Therapy

2. Jurisdiction B answered the following question in the January 13, 2011 Question and Answer document:

With regards to the September 9th publication titled *Request for Refill-Documentation from Region A*, please clarify the following:

Part one written document: For items that are delivered to the beneficiary's home, would the delivery ticket suffice as to the written document? Most of the items required are already included in the delivery ticket because they are required by the proof of delivery instructions in the manual.

- Beneficiary's name
- A description of each item or of each type of item that is being requested (e.g., diabetic testing supplies, inhalation drugs, nebulizer accessories, etc.); a list of each separate item is not required
- A statement that the beneficiary is requesting a refill of the items
- Beneficiary signature (If signed by a caregiver, indicate relationship to beneficiary)
- Date of signature

ANSWER:
Part 1: For items delivered to a beneficiary's home, a delivery slip would not be appropriate documentation of a request for refill. The purpose of the request for refill is to determine whether the beneficiary needs more supplies before the delivery is initiated.

Part 2: Concerning phone conversation, the beneficiary's name must be clearly linked to their request for refill response.

Part 3: Response: Many of the DME MAC LCDs contain the "must check" requirements for need prior to shipping. These requirements are based on the Program Integrity Manual (Internet-Only Manual 100-8) Chapter 4, Section 4.26.1) and exceptions cannot be granted.

I would like a clarification if a delivery ticket would be acceptable for proof of refill documentation if it were computer-generated with a date and time stamp when we had contact with the patient? It would also indicate that the beneficiary is requesting a refill of the attached supplies. Our business practice is to complete the delivery ticket online while speaking with the patient. The delivery ticket automatically prints the date and time when the ticket is created. Would this be sufficient documentation?

ANSWER: The request for refill and proof of delivery are two separate documents. The request for refill is to be completed no sooner than 7 days prior to delivery and if contacted via phone conversation must contain all of the following:

- **Beneficiary name**
- **Person contacted (i.e., beneficiary or caregiver [list name])**

- **A description of each item or of each type of item that is being requested; a list of each separate item is not required**
- **A statement that the beneficiary is requesting a refill of the items**
- **Date of contact**

The delivery ticket should not be completed with a preprinted date prior to delivery as you indicated in your question. The proof of delivery form is to be signed and dated by the beneficiary or designee at the time of delivery. These two forms have separate requirements and are completed at separate times. For additional information regarding proof of delivery requirement documentation, refer to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual, Publication 100-08, *Medicare Program Integrity Manual,* Chapter 4, Section 4.26.1.

3. When a supplier has determined that coverage criteria are met for a specialty formula and has clinical documentation supporting it, then should the supplier bill without using any upgrade (GK, GL) or denial (GA, GZ, GY) modifiers and expect to receive full payment on the specialty code from the DME MAC? Does the DME MAC agree that in such a case that the supplier would in effect be attesting that the patient is qualified for the additional coverage criteria and therefore none of these modifiers are to be used?

ANSWER: Yes, that is correct. If a claim with a HCPCS code for a specialty enteral formula is submitted to the DME MAC and the beneficiary meets all of the specific additional coverage criteria outlined in the local medical policy, the item will be paid in full, and upgrade modifiers are <u>not</u> required. However, suppliers are cautioned that if during the course of an audit (i.e., CERT, RAC, Medical Review, etc) it is determined that the coverage criteria are <u>not</u> met they will be required to refund the entire payment to Medicare.

Respiratory Care Equipment/Oxygen Therapy

4. We receive orders from a hospital that obtains qualifying oxygen test results from patients prior to discharge from the hospital by doing spot checks. When they obtain these test results they document the results in the patient's medical records (e.g., "oxygen saturations ranged from 86-89% on room air during rest"). Will Medicare accept these test results to qualify the patient or do the results need to be printed lab results from the machine that took the test?

ANSWER: Yes, if the results were obtained while the patient was in a chronic stable state, within two days prior to discharge from the hospital, Medicare would accept the result as described above to qualify the patient for home oxygen therapy. Additionally, the hospital record must show the identity of the person performing the test. The conditions under which the test were performed must be described. In the case of an audit, the hospital must have documentation to show the training and qualifications of the person who performed the qualifying oxygen test.

5. There is a new PAP product on the market, the REMZZZS Liner Pap for full face masks. This liner is a one time use item and is sold in a box of 30 (one month supply). We have checked with the manufacturer and the DMECS Web site and according to both the item should be coded as A7031. The HCPCS code description for A7031 states the following: face mask interface, replacement for full face mask, each. Medicare policy allows 1 A7031 per month and the fee schedule allowance is $63.08. We only bill $29.95 for the REMZZZS liner, also classified as A7031. We are concerned that the coding for the REMZZZS Liner is not correct and will result in the fee schedule allowance for the actual face mask being decreased in error. Who should we contact to have the coding reviewed and possibly changed?

   ANSWER: If suppliers are concerned about coding, they should contact the Pricing, Data Analysis, and Coding Contractor (PDAC) at www.dmepdac.com.

6. If a Medicare beneficiary has a qualifying sleep study in 2006, but the beneficiary refused to start PAP therapy. However, in 2011, the patient was hospitalized and the physician has prescribed PAP therapy. Is the patient required to have another sleep study? If not do we just need a current face-to-face evaluation? If a new sleep study is required and the beneficiary refuses to be tested again can we execute an ABN?

   ANSWER: The beneficiary should receive a new qualifying sleep study in this circumstance. A 5 year gap between the sleep study and the institution of treatment is not reasonable. If the beneficiary will not obtain a new sleep study and therefore would not meet coverage criteria, you may execute an Advance Beneficiary Notice (ABN) in this situation. For additional information regarding ABNs, refer to chapter 10 of the Jurisdiction B Supplier Manual.

7. If a Medicare beneficiary has a PAP device in need of repair our company sends the PAP device to the manufacturer to make the repairs. In most cases the equipment warranty has expired but the equipment is less than 5-years old. Often times the manufacturer will evaluate the equipment and determine that the cost of the repair is more expensive than replacing it and will provide a replacement to us at a discounted rate.

   How do we bill this to Medicare? Do we bill Medicare for the new PAP device under HCPCS code E1399? If we can't bill as E1399, how do we bill as a replacement for the discounted unit since it is less than five years old?

   ANSWER: Medicare does not cover replacement of a PAP device prior to the 5 year reasonable useful life (RUL) unless the item has been stolen, lost, or irreparably damaged. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc). For additional information regarding replacement of DMEPOS items, refer to the CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 20, Section 50.1.

8. If a patient comes in for CPAP supplies and all of the supplies are listed on the dispensing order as well as the quantities of the supplies will this suffice as the detailed written order for the first month or do I still need frequency?

   ANSWER: No. It would suffice as the dispensing order but you would need to follow up with a detailed written order with the quantity to be used, frequency of change, and length of need for each supply prior to billing Medicare. If a dispensing order were to contain all of the above elements, then it could be used as the detailed written order (DWO).

Prosthetics/Orthotics

No question submitted.

Rehab Equipment

9. Physician prescribes K0822 standard power wheelchair with a basic seat cushion. Under the current policy, the provider would bill K0822 + E2601; Medicare will process and pay the allowable for the captain's seat K0823 (which is slightly less then the combined K0822 plus cushion E2601).

   Under the new policy effective 02/04/2011, the policy states that both the K0822 and E2601 would be denied. There are situations where a beneficiary has fragile skin but does not have a history of decubitus ulcers. Therefore, it may be more appropriate to provide the K0822 PWC with the basic E2601 seat cushion; if they then develop skin issues, they can qualify for/receive the appropriate higher level cushion and use it on the PWC that Medicare has paid for – without requiring a much more expensive change in seating systems or a whole new PWC. So if it is in the best interests of Medicare and the beneficiary to provide a K0822 with an E2601 cushion, is there a way to bill this using the upgrade provision? May the provider combine and bill as K0823 with the GL modifier (assuming they provide as free upgrade), with the narrative explaining that a K0822 and E2601 was provided? If that is not the way to submit the claim, how can it be done? It seems to be unnecessarily harsh to deny any otherwise qualified PWC base without a way to handle this.

   ANSWER: At this time the policy does not allow for suppliers to bill the K0822 with an E2601 instead of the K0823. It is recommended that suppliers gather literature and findings substantiating such described clinical situations and submit a local coverage determination (LCD) reconsideration. For additional information on submitting an LCD reconsideration refer to the Jurisdiction B DME MAC supplier manual, Chapter 6.

10. Beneficiary receives a Group 4 PWC but qualifies for the equivalent Group 3. Prior to the new policy 02/04/11, if KX was added to the claim for the Group 4 base, Medicare would automatically downcode and pay the Group 3 allowable. Starting 02/04/11, the Group 4 base will be denied. Please confirm that it would be appropriate for providers to bill using one of the

upgrade options (two lines with bene payment and ABN; or one line with GL if done as 'free' upgrade) if providing a Group 4 base.

ANSWER: A News Article was sent out via listserv on April 29, 2011:

Upgrades to Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886)
Recent revisions to the Power Mobility LCD eliminating Least Costly Medically Necessary Alternative classified the denials for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) as statutorily non-covered. This determination caused the unintended consequence of making these items ineligible for the Advanced Beneficiary Notice (ABN) upgrade process. The LCD and Policy Article are being revised to indicate that denials for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are not reasonable and necessary. This change will be effective for dates of service on or after June 1, 2011.

Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are covered under the Durable Medical Equipment Benefit. In addition to capabilities that allow Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) to be used in the home, they also have certain performance characteristics that are not reasonable and necessary for use in the home such as (not all-inclusive):

- robust frames
- motors with increased torque/power
- suspensions with enhanced vibration-dampening or obstacle climbing capabilities

The revised Power Mobility Devices LCD and related policy article will reflect that claims for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) will be denied as not reasonable and necessary. As a result, Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) <u>are</u> eligible for the ABN upgrade provisions as set out in the recently published bulletin article on the use of upgrade modifiers as a result of changes due to elimination of least costly alternative.

Refer to the LCD, Policy Article, and Supplier Manual for additional information on upgrades and Power Mobility devices. The Power Mobility Devices LCD and Policy Article revisions will be published in the near future.

Ostomy/Urological/Medical Supplies
No Questions Submitted.

Diabetic Monitoring and Supplies
No Questions Submitted.

Documentation/Regulatory/Miscellaneous/Other
11. If a non-participating DMEPOS supplier would like to sell an item to a Medicare beneficiary that Medicare will only pay as a rental (i.e., nebulizer) or Medicare requires rental prior to purchase (i.e., TENS unit), can the non-participating supplier sell the item out-right to the

Medicare beneficiary on a non-assigned basis, and execute an ABN holding the beneficiary financially liable? The ABN would state the following: "Medicare will not pay for the item if purchased up front, the item must be rented".

ANSWER: An ABN should be issued prior to dispensing a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) item expected to be disallowed for the following reasons:

- **Services are not medically reasonable and necessary**
- **Prohibition on unsolicited telephone contacts**
- **Supplier number requirements not met**
- **Advance Determination of Medicare Coverage (ADMC) denial**
- **Noncontracted suppliers in a competitive bidding area (CBA)**

It would not be appropriate for a DMEPOS supplier to execute an ABN in order to bill for the purchase of a DMEPOS that is required to be rented per Medicare guidelines. There are no exceptions to this rule simply because the supplier elects to be a non-participating supplier. For additional information on ABNs, refer to the Jurisdiction B DME MAC Supplier Manual, Chapter 10.

12. Is there documentation available that indicates that each supplier location that dispenses DMEPOS items must have a separate supplier number? Our company has multiple locations in the same city, many patients get supplies and equipment from each of the locations. We want to bill from just one location in that city rather than billing from each of the locations for the same customer.

ANSWER: The CMS 855-S enrollment form states the following:

> **A. BUSINESS LOCATION INFORMATION**
> **This section captures information regarding your business location.**
>
> **A separate application must be submitted for each physical business location that intends to bill Medicare for items sold to Medicare beneficiaries from that location. Locations that serve only as warehouses or repair facilities should not be reported.**
>
> **Note: You must separately enroll each Medicare DMEPOS supplier business location.**

If you have any additional questions related to the DMEPOS supplier enrollment process, contact the National Supplier Clearinghouse at www.PalmettoGBA/NSC.

13. If a supplier provides a medically necessary capped rental item (i.e., nebulizer) to a patient on January 1, 2009 and they bill the first five months of rental and receive payment but due to a

billing system error months 6-9 (June-August, 2009) are held and not billed to Medicare. The error is corrected and claims are submitted for months 10-13 (September – December, 2009). The supplier performs an internal audit and realizes that only 10 rentals have been paid because June-August, 09 were never submitted. The claims are now past the time filing limit. What should the supplier do?

- Bill Medicare for 3 additional months that are within the time filing limit, in order for Medicare to register that 13 rentals have paid?
- Bill the months that are past the time filing limit and receive a denial?
    i. Will Medicare show that 13 rentals are paid when really only 10 rentals have paid?

ANSWER: If the supplier determines that 13 monthly rentals have <u>not</u> been submitted to Medicare on a capped rental item, the supplier should determine whether or not the missing rental months are past the timely filing limit. If the missing rental months are still within the timely filing limit, which is within one calendar year after the date of service, the supplier should simply submit the missing rental months. However, if the supplier determines the claims are past the timely filing limit the supplier should submit 3 additional rental months that are within the filing time limits. If the CMN record on file with Medicare which is used to keep track of rental payments has an end date prior to the dates of service submitted billed, the supplier will need to have the CMN record updated to extend the end date. This must be done by submitted a redetermination request in writing.

14. There are new 'definitions' of replacement parts vs. repair parts and the use of the RA/RB modifiers in the Competitive Bid DME Repairs and Replacements Fact Sheet; do these same definitions and usage for RA/RB modifiers apply to claims for beneficiaries who do not live in CBAs?

ANSWER: The RA and RB modifiers and their definitions apply to claims for repairs and replacements submitted by DMEPOS suppliers regardless of whether the beneficiary resides in a CBA.

Follow up question: Suppliers have received conflicting responses to the same question. Other jurisdictions are indicating that the new definitions and usage of RA/RB modifiers only apply to beneficiaries who reside in the CBAs. Can you please clarify this response?

ANSWER: In 2008, the RP modifier was replaced with the RA/RB modifiers. The RA/RB modifiers apply to all DMEPOS claims for repairs and replacement submitted by suppliers regardless of whether the beneficiary resides in a CBA or not.