**Jurisdiction B Council A-Team Questions**
**Sorted by A-Team**
**May 3, 2012**

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**Home Medical Equipment**
**No questions submitted.**

**Enteral/Parentral/IV Therapy**

1. We would like clarification on coverage of a feeding pump B9002. The policy states the patient has to have a permanent non-function or disease of the structures that normally permit food to reach the small bowel, or 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 patient's overall health status. If a patient has severe reflux disease, with nausea, vomiting and aspiration, would he qualify for a feeding pump to regulate the flow if gravity and syringe feeds haven't been able to provide him with adequate nutrition without further reflux, vomiting and aspiration?

   **Answer: Assuming the beneficiary meets the requirements for coverage under the prosthetic benefit, yes. The Enteral Nutrition Local Coverage Determination (LCD), under Equipment and Supplies states the following:**

   **"If a pump (B9000-B9002) is ordered, there must be documentation in the patients' medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not reasonable and necessary."**

   **In order to meet the coverage criteria for an enteral nutrition pump, the beneficiary has to have a problem with "reflux and/or aspiration," and a beneficiary with severe reflux disease who has aspiration therefore qualifies. We do not require a certain pathology to be the cause**

**of the aspiration. In other words, it is not about the cause of the aspiration, only that aspiration is occurring.**

**Respiratory Care Equipment/Oxygen Therapy**

2. Medicare patient on Bilevel Positive Airway Pressure (BIPAP), failed the trial period and the machine was returned. One year later, through an office visit the doctor recommended the patient start using the machine again. The policy states when a patient fails the 12 week trial in order to re-qualify they must have a face to face clinical re-evaluation and a repeat sleep test. The test may be a diagnostic, titration or split night. The physician ordered only a titration study. Is there a length of time in between the initial trial and being restudied before the patient would have to start all over with a diagnostic study to re-qualify? Or because the patient already had the diagnostic study a titration study would be acceptable?

   **Answer: For obstructive sleep apnea (OSA) in the Positive Airway Pressure (PAP) policy, the study has to be repeated, and it can be any one of the three.**

3. Medicare patient failed 3-month trial on BIPAP therapy in 2008. In 2012, the patient had a face-to-face office visit and new diagnostic study. Since the patient previously could not tolerate Continuous Positive Airway Pressure (CPAP) therapy in the past, can the titration study only be on BIPAP or does CPAP need to be proven ineffective again?

   **Answer: The current PAP policy requires that the process start again.**

4. To begin a new reasonable useful lifetime (RUL) for the E0471 what documentation is needed? If the patient had a face-to-face office visit with the treating physician that documented use and benefit of the E0471 along with the initial testing that qualified the patient for coverage, would this information suffice to begin a new RUL? Would the patient need to meet the continued coverage criteria as outlined in the policy for the new machine?

   **Answer: This is a confusing question because it requests clarification on CPAP requirements for a Health Care Common Procedure Coding System (HCPCS) code which is not covered in the PAP policy. E0471 requirements are located in the LCD for Respiratory Assist Devices. However, in general, items being replaced due to RUL being met only require a new prescription and there is no need to conduct new testing or to re-qualify by way of testing - assuming that the item has been in *continuous* use in the prior 5-year period.**

5. If a beneficiary had oxygen for 14 months from a different provider starting back in 2006 and it was picked up because the need ended, do we, as the new 2012 provider, request a break in service (BIS) or can we start a new rental period because it has been 5 years?

**Answer: In order to qualify for a new rental period, there must be information in the medical record showing that the medical need ended in 2006 and what the medical condition(s) is in 2012 that establishes a new medical need. If the 2012 medical need is indeed due to a new medical condition rather than a continuation of the former medical condition, then the oxygen equipment may be eligible for a new rental reimbursement cycle. The beneficiary should have been in a chronic stable state in 2006. If the beneficiary stopped using the oxygen due to non-compliance, the supplier had to stop billing for it. Five years later, the new supplier should pick up with the rental periods if it is for the same, although worsened, condition.**

**It is unlikely that the medical condition – as per the policy, a chronic condition - for which the original use of the covered device (whether it be oxygen or another) got "better" so that there now exists a completely new and different medical condition for which a new rental period would be justified. However, it could happen. Additional information on break in need can be found in the Interruptions in a Period of Continuous Use Flow Chart, which is located on the National Government Services Web site under Resources, Tools and Materials, Self-Help tools.**

**6.** If a beneficiary is being discharged from a Part A nursing home stay can the nursing home do the oxygen saturation test to qualify for oxygen? Per policy "the test must be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider (the nursing home is a part A provider and patient is in a part A stay), a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician."

We did find the answer in the Medicare Training Summaries 3-23-2011 Oxygen and Oxygen Equip. #4 and the response was: A nursing home is not considered a qualified provider or a qualified laboratory for purposes of the oxygen and oxygen equipment LCD. Testing must be performed by a Medicare qualified provider (i.e., Part A provider, laboratory, Independent diagnostic testing facility (IDTF)), who is eligible to bill Medicare for the qualifying test. The response seems to be at odds with the "Medicare qualified provider including a Part A provider" statement? Please clarify.

**Answer: As indicated in the question, the Oxygen and Oxygen Equipment LCD indicates the qualifying blood gas study must be performed by a provider who is qualified to bill Medicare individually for the specific test performed. Our understanding is that generally a nursing home would not be qualified to bill Medicare for this individual test to be performed. The nursing home may arrange for the properly qualified entity to perform the test. This provider would have to be qualified to bill Medicare Part A or B for the individual test performed.**

**Update: The standard for determining that a tester is "a qualified provider of laboratory services" is that the tester must be qualified to bill Medicare for the test provided. Simply**

**having all costs bundled into a Part A payment is not sufficient evidence of being a qualified provider of laboratory services. If the skilled nursing facility (SNF) is a Part A provider and holds a Clinical Laboratory Improvement Amendments (CLIA) certificate, would this mean it qualifies? No, they have to be qualified to bill Medicare for the test provided. This alone would not qualify. Please request information from your carrier for Part A services for more details about this.**

**7.** If an oxygen claim is audited by Medicare, do oxygen saturation testing result records performed by and signed by the respiratory therapist who performed the test need to be co-signed by the physician? I don't believe there is any information regarding signatures on tests. Policy has no indication of signature required on the test results, is this required and if so, where is the policy defining this rule?

**Answer: The Medicare Durable Medical Equipment Medicare Administrative Contractors do not require oxygen saturation tests to be cosigned by the physician.**

**8.** Would oxygen saturation test results obtained in the emergency room on a patient who was stabilized and released as safe to discharge satisfy the Medicare requirement of "chronic, stable state"?

**Answer: The patient must be in a chronic stable state and not acutely ill. The national coverage determination (NCD) defines chronic stable state as "…not during a period of an acute illness or an exacerbation of their underlying disease." Based on this NCD definition, all co-existing diseases or conditions that can cause hypoxia must be treated and the patient must be in a chronic stable state before oxygen therapy is considered eligible for payment.**

**Prosthetics/Orthotics**

**9.** What HCPCS is to be used for lymphedema compression bras?

**Answer: Medicare does not cover compression garments for lymphedema management because they do <u>not</u> fall within any benefit category. Therefore, lymphedema compression bras will be denied as statutorily noncovered. Because they have not been assigned a specific HCPCS code, they should be billed under HCPCS code A9270.**

**10.** Per the LCD for post mastectomy it states that a supplier must not dispense more than a 3-month quantity of "supplies" and accessories at a time. What is considered a three-month supply?

**Answer: The policy does not define these parameters. The number of bras should be reasonable for how the beneficiary uses them, and the number should be justified in the medical record.**

Should mastectomy bras (L8000) follow Medicare policies for periodic supplies?

**Answer: This is not necessary for mastectomy bras.**

What is required on the detailed order for mastectomy bras (L8000)?

**Answer: A detailed written order (DWO) must contain the following:**

- **Beneficiary's name**
- **Physician's name**
- **Date of the order and the start date, if start date is different from the date of the order**
- **Detailed description of the item(s)**
- **Physician signature and signature date**

**Rehab Equipment**

**11.** We understand that there is no separate billing for a safety belt when it is deemed medically necessary for an individual to safely operate the Power Operated Vehicle (POV) and provided at initial issue. The Correct Coding - Safety Equipment Packages with Power Operated Vehicles communication posted to Noridian's Web site on December 15th states, "For correct coding all POVs must have all components listed in the Basic Equipment Package." Does this mean that a safety belt is a required item that must be included with the POV at initial issue in order for it to be properly coded (K0800 - K0808, K0812) and billed to the DME MAC?

**Answer: Yes, the safety belt is included in the HCPCS coding for POVs. How a manufacturer provides material to a supplier is not dictated by the DME MACs.**

**12.** If a safety belt is required to be included on all units:

a. What is the reason for this change?
b. Will the policy be updated to clearly indicate that a safety belt is part of the basic equipment package (BEP), similar to the power wheelchair (PWC) BEP?
c. What will the formal notification be and when should providers expect to see that?
d. When and how will manufacturers be formally notified of this requirement?
e. How will a claim be properly adjudicated when a pelvic belt is contraindicated or deemed not medically necessary for the safe use of the POV?

**Answer: This is not a change to the policy or HCPCS coding for POVs. When these devices were coded through the Pricing Data Analysis and Coding Contractor (PDAC) they included the safety belt in the pricing.**

**13.** If a safety belt is only required when there is documentation that it is required for the safe operation of the POV, and not required on all units to be correctly coded (K0800 - K0808, K0812):

f. Will manufacturers and the PDAC be notified that a safety belt is not required for correct coding (K0800 - K0808, K0812) of a POV?

**Answer: See response to question #11.**

**14.** If a claim for the first month of a power wheelchair capped rental is denied but is subsequently paid in redeterminations (or some other stage of the review process) and subsequent months have denied in the interim, must those subsequent claims also go through the review process once the initial month has been paid or can they be adjusted (or another action taken)?

**Answer: The supplier would have to go through the review process for each of the claims denied.**

**Ostomy/Urological/Medical Supplies**

**15.** We provide non-sterile gloves (A4927) for non-end stage renal disease (ESRD) patients and need a patient responsibility (PR) denial for secondary insurance. Several secondary insurance companies do not like and will not accept the OA-109 denial. Should we bill as A4927GY? We have tried to bill this way but we receive a CO-109 denial, "Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor." Should an ABN be executed so that we can get a PR denial for secondary insurance?

**Answer: The Centers for Medicare & Medicaid Services (CMS) issued instructions regarding End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services, the instructions included non-sterile gloves (A4927) and indicated that they are no longer separately payable to DMEPOS suppliers. National Government Services has received numerous inquiries regarding this issue and understand that suppliers are not expecting payment but instead are looking for a patient responsibility denial for secondary insurance purposes. According to CMS instructions these claims are being processed correctly and suppliers are receiving the correct denials. However, we have elevated these concerns to CMS and once we receive a response we will update the supplier community via an e-mail update.**

**16.** What is the proper way to bill for an extra quantity of leg bags (A4358) and drain bags (A4357)? We have an ABN signed for the "upgraded" quantity and bill using the GK modifier. We are still receiving the CO-50 denial.

a. Should it be billed on two lines with the full amount on first line and allowed quantity on the second line and should both the GK and KX modifiers be used on the second line? Example: A4358GA 4 UNITS, A4358GKKX 2 UNITS

**Answer: Generally, if the quantity of supplies ordered/requested exceed the standard amount specified in the LCD, or if the supplier does not have information from the beneficiary's medical record that supports the need for the excess quantities, the supplier may execute an Advance Beneficiary Notice of Noncoverage (ABN). If an ABN is executed, the supplier may charge the beneficiary for excess quantities. In this situation the excess**

**quantity is billed as an upgrade. However, suppliers are reminded that if the items billed have an established medically unlikely edit (MUE), you cannot utilize an ABN "under any circumstance" to bill a Medicare beneficiary for items denied due to the MUE.**

**17.** We would like clarification as to the definition of a "closed" wound. Medicare states:

TRANSPARENT FILM (A6257–A6259):

Transparent film dressings are covered when used on open partial thickness wounds with minimal exudate or closed wounds. Usual dressing change is up to 3 times per week.
Per Medicare's policy, dressings are covered for a wound caused by, or treated by, a surgical procedure; or they are required following debridement of a wound.

What is the definition of a "closed" wound? Do they mean surgically closed wound? We had a customer whose doctor prescribed tegaderm to be used over the area of a newly healed "closed" wound to protect the skin when donning compression stockings. Per the policy, I wouldn't think it would be covered but the narrative listed under the tegaderm is confusing.

**Answer: "Closed wounds" are those which have been surgically closed.**

**Diabetic Monitoring and Supplies**

No questions submitted.

**Documentation/Regulatory/Miscellaneous/Other**

**18.** Is a DME provider permitted to execute an ABN for an item we are not accredited for? If we do execute an ABN and the reason is we are not accredited, are we then permitted to bill with a GA modifier?

**Answer: Non-accredited suppliers should use an Advance Beneficiary Notice of Noncoverage (ABN) before providing a Medicare beneficiary with an item or service to alert the beneficiary to the fact that the supplier is non-accredited and unable to bill Medicare for the item. The CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30 states that issuance of an ABN is mandatory in the following situations:**

- **Services are not medically reasonable and necessary**
- **Prohibition on unsolicited telephone contacts**
- **Supplier number requirements are not met**
- **ADMC denial**
- **Noncontracted suppliers in a CBA**

**Receipt of the properly completed ABN provides the beneficiary with the necessary information to make a decision to either receive the item from the non-accredited supplier and pay out-of-pocket, or obtain the item from a different supplier.**

**19.** Request for refill documentation – if the patient sends our company an email requesting a refill of supplies, if the email contains all of the required elements, is an email acceptable? Would it be considered a written document? If so, the written requirement states we must have a date of signature, would the email printed out in our charts be considered a signature? Or would we have to follow up with a telephone conversation and document the telephone conversation?

**ANSWER: For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. 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 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**
- **Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date**

**The request for refill documentation does not require a signature. An e-mail from the beneficiary can be considered a written document. You should maintain a copy of the e-mail sent by the beneficiary requesting the refill for auditing purposes. A follow-up telephone conversation would not be necessary if the e-mail contains all of the required elements.**

**20.** When it comes to proof of delivery, when using a shipping service, if we are using an outside company to pack and ship our items, and they obtain an email from the shipping service, i.e. USPS, FED EX or UPS, with all the valid items, confirming the shipment, is the email alone with the information considered proof of delivery or does it have to be an official tracking slip from the delivery service?

**Answer: An e-mail from the shipping service is acceptable as long as it contains all of the required information.**

**If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification**

**number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:**

- **Beneficiary's name**
- **Delivery address**
- **Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.**
- **Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)**
- **Quantity delivered**
- **Date delivered**
- **Evidence of delivery**

**21.** Is a provider permitted to use a reason such as "unable to obtain medical documentation to support the CPAP and supplies required by Medicare" or a reason as "the service will not be covered since the coverage requirements are not met" as opposed to be more specific to the scenario? Or does the reason on the ABN have to be an exact reason?

**Answer: It is permissible to issue an ABN when the supplier has determined that the applicable coverage requirements for the requested item are not met. The ABN is required to be detailed and specific in discussing the coverage requirements and why the beneficiary's condition renders them ineligible for reimbursement. For policies where there is an explicit documentation collection requirement, e.g., PMDs, TSD, any CMN requiring policy (not all-inclusive), a refusal from the treating physician to provide the Medicare policy-required documentation would be an appropriate justification to issue an ABN. However, most policies do not have specific or explicit documentation collection requirements. Many suppliers, on their own initiative, request medical records for their files. A failure to obtain these supplier-requested documents would NOT be sufficient reason to obtain an ABN.**

**22.** I would like the council to clarify question #19 in the January 26, 2012 Question &Answer (Q&A). We have been told it was acceptable to present an ABN when we have attempted to get medical records but they are not provided before service is provided.

A participant in an industry seminar stated that Jurisdiction B indicated that you could use an ABN in this instance and provided follow up documentation in the form of a Frequently Asked Question (FAQ) (#32). I provided copies of the FAQ to representatives from CGS (formerly CIGNA) and Noridian. Noridian responded that they agree with the FAQ and CGS responded similarly although cautioned that the supplier must be able to show proof that made attempts to collect the documentation up front and failed. They also indicated that this should not be used multiple times for the same physician as indicated in the FAQ.

The example in Question 19 is a poor example as there is rarely an "immediate need" for a lift chair to be delivered. However, an oxygen order where we are unable to obtain test results from the referral source after a number of attempts that day would still need to be delivered w/ out the medical necessity information since it is a patient safety issue.

Is it acceptable to obtain an ABN for lack of medical necessity documentation in these situations?

**Answer: See the response to question #21. Note again: Many suppliers, on their own initiative, request medical records for their files. A failure to obtain these supplier-requested documents would NOT be sufficient reason to obtain an ABN.**

**23.** Please provide directions of how to submit claims for denial for items we know will not be covered by Medicare, when it can't get through the front end edits. We have alternative funding sources but they require a denial.

**ANSWER: This issue was raised by Council during a previous meeting and is included in the open action items.**

**24.** With all the use of Electronic Medical Records (EMR), can a doctor's office or hospital system create a CMS CMN (i.e., CMS 484 oxygen CMN) in their EMR program such as EPIC, with both sides of the CMN fully duplicated, and have physicians and their staff complete the CMN and sign electronically?

**Answer: The CMS Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual*, Chapter 5, Section 5.3 states the following: Suppliers and physician may choose to utilize electronic Certificate of Medical Necessity (CMNs) (e-CMNs) or electronic DME Information Forms (e-DIFs). E-CMNs or e-DIFS must adhere to all privacy, security, and electronic signature rules and regulations promulgated by CMS and Department of Health and Human Services (DHHS). Additionally, e-CMNs or e-DIFs must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/definitions as printed on the back of the hardcopy form.**