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

1. On nonassigned claim denials primarily for seat lift mechanisms (E0627) several patients have insisted that we obtain a new CMN and resubmit the claim. The claims have denied due to lack of medical necessity due to the way the physician completed the questions on the original CMN. However, the patient or caregiver insists that the patient does meet coverage criteria and the treating physician simply answered the questions incorrectly the first time. Is there a requirement that we obtain a new CMN from the ordering physician? Is it considered compliant to ask the treating physician to complete another CMN to support medical need?

   ANSWER: A CMN is required to help document the medical necessity and other coverage criteria for the seat lift mechanism. However, a CMN does not stand alone to support medical necessity. If the beneficiary or caregiver has reason to believe they meet Medicare coverage criteria and the physician simply answered one of the questions in Section B of the CMN incorrectly, the supplier should follow up with the ordering physician to verify this information. If the treating physician has medical records to document the patient's need for the seat lift mechanism and determines that, in fact, the question was answered incorrectly, and if there is already a claim denial, the supplier will need to file a Redetermination with the supporting medical necessity documentation. Please note that the documentation must be from physician visits prior to the date of service on the claim.

2. Walker policy states: Codes E0154, E0156, E0157, and E0158 can be used for accessories provided with the initial issue of a walker or for replacement components. Why is E0154 only covered when walker is dispensed or as a replacement? If someone needs a walker due to a broken arm and/or stroke is the E0154 not covered?

ANSWER: Yes, the walker would be eligible for coverage if it was added at a later time due to a change in medical necessity.

3. Does an RT, LT, or RTLT modifier need to be added to a walker platform attachment E0154? Modifiers are not in the policy.

   ANSWER: No, the RT, LT modifiers are not required for the walker platform attachment HCPCS code E0154.

Enteral/Parentral/IV Therapy

4. We service long-term care facilities and deliver our supplies for enteral on a weekly basis. Most facilities do not have the storage room to keep a month's worth. In the past the industry has billed from the beginning of the month to the end. If we have all of our delivery receipts, why can't we bill for an entire month? Billing on a weekly basis is more labor intensive for both the supplier and Medicare.

   ANSWER: Suppliers have the option of billing for enteral nutrition prospectively (up to a one month supply) or retrospectively. If the supplier ships enteral nutrition to a long-term care facility for a beneficiary on a weekly basis, the supplier may submit one claim for the entire month's supply at the end of the month. Suppliers may <u>not</u> bill prospectively for the entire 28-day supply unless/until the entire 28-day supply has been shipped.

   Example: The supplier ships a seven-day supply of nutrition to the beneficiary on April 1, April 8, April 15, and April 22. In total, the supplier shipped a 28-day supply. The supplier may submit one claim after the final weekly supply has been shipped (i.e., April 22). The supplier indicates the date of the initial shipment (04/01/10) as the "From" date on the claim. The "To" date is determined by counting 28 days from the "From" date, in this case, 04/28/10.

Respiratory Care Equipment/Oxygen Therapy

5. PAP question: If a physician interpreting a sleep study is an active member of a hospital-based sleep lab, and the hospital is accredited by the Joint Commission, does that satisfy the requirement in the LCD?

   ANSWER: Yes, if the hospital accreditation included the sleep lab, that would be sufficient.

6. We have been receiving CO-97 denials on liquid oxygen contents claims for some patients who have capped-out liquid oxygen stationary and portable systems. We have had to send reopening requests on these patients every month since last June. Can this not be corrected? This situation only occurs with liquid oxygen contents claims.

   ANSWER: National Government Services would need claim examples to research the Medicare claims processing system to determine the cause for the denials.

7. Is a provider required to obtain documentation of compliance (four hours or more per day on 70 percent of days in 30-day period) in the first 90 days on CPAP patients who have had their CPAP replaced due to the five-year useful lifetime replacement policy?

ANSWER: No. The most recent revision of the LCD stated that if a CPAP initially covered by Medicare is replaced, there is no requirement for another trial period.

8. We are having problems with sterile water (A4217) being denied. We are receiving denial CO-16 and, per the medical policies, when they are used with suction equipment no modifiers are required. Is this correct, no modifiers for suction coverage?

ANSWER: Medicare does not require modifiers to be billed with HCPCS (A4217) when the sterile water is used in conjunction with a suction pump. National Government Services was aware that claims were being denied inappropriately and have resolved this issue. Suppliers will need to resubmit denied claims for payment.

9. Can a physician sign a recertified oxygen CMN prior to the recertification date?

ANSWER: There is a requirement for a physician visit within 90 days prior to the recertification. The recertification CMN may be signed after that visit has occurred.

10. The policy for the PAP device is that a face-to-face meeting is needed after a patient is enrolled with Medicare. Is the enrolled date when they applied for Medicare fee for service or when they became effective with Medicare fee for service? If it is the applied date for Medicare, how can we find out that date? Many times these patients have seen the doctor a few months before their effective date and we are making them go back for another visit for compliancy of the PAP policy. Is there any type of communication to the patient that when they enroll in Medicare fee for service, that they need to see their physician to document any continued medical need of equipment that they are using?

ANSWER: The enrolled date is when they became effective with Medicare fee-for-service. To the best of our knowledge, there is no specific communication with the beneficiary regarding the requirements for ongoing coverage of DME received prior to enrollment.

11. MLN Matters Number MM6792 on Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010, states you must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. In the example given it states: 36th monthly payment amount made for month ending July 31, 2010. Six-month period with no payment ends December 31, 2010. Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on July 31, 2010, or earlier. You must make at least one in-

home visit during January 2011 and payment covers all maintenance and servicing through June 30, 2011. In this example, what if you make the in-home visit during February 2011 and not in the first month? Can you bill for February 2011 and would this cover all maintenance and servicing through July 31, 2011? We would like a clarification that you can receive reimbursement for the maintenance and servicing as long as it is six months or longer with no payments.

ANSWER: National Government Services is currently seeking clarification from CMS regarding this question.

12. If a patient is on oxygen E1390 and portable gas, and later the doctor requests that the patient switch to liquid, if the original provider does not provide liquid, can a new provider set up the patient on liquid stationary and liquid portable (E0439 and E0434) and get 36 months payment for oxygen since the initial provider could no longer meet the needs of the patient per the doctor's prescription?

ANSWER: No, if the patient utilized E1390 and gaseous portable equipment and the supplier received the 36th months payment then the supplier would be obligated to provide the patient with oxygen equipment during months 37-60. If the supplier does not provide liquid stationary and liquid portable oxygen they would need to contract with a supplier in the patient's service area that does. If the supplier has not received 36 months of payment the supplier would need to assist the beneficiary with locating a supplier that was willing to take them on as a patient and provide liquid portable oxygen.

13. A sleep lab that controls many referrals has blatantly stated that they will refer RADs only to providers who will set up the clients and bill Medicare based solely on a verbal order. The lab's physician will not sign any written orders or provide other initial or follow-up documentation. What can be done to 'educate' the lab to help them understand that they are asking providers to be noncompliant with Medicare regulations?

ANSWER: The Jurisdiction B DME MAC Medical Director, Dr. Oleck, wrote a letter that suppliers can print and send to a physician and which outlines the requirements physician and nonphysician practitioners must follow when ordering DMEPOS items. Suppliers should send this letter, along with a copy of the LCD and policy article, to the sleep lab. If the sleep lab continues to indicate it will not comply or will only refer patients to suppliers who are noncompliant, they should be reported to the local Part A and B Fiscal Intermediary or Carrier Program Safeguard Contractor (PSC). If suppliers are aware that DMEPOS suppliers are accepting verbal orders from the sleep lab and not obtaining the detailed written order and/or other required Medicare documentation, the DMEPOS supplier should be reported to the DME MACs.

Prosthetics/Orthotics

14. Does Medicare pay for both the silicone prosthesis L8030 and the leisure form L8020 at the same time or within the same year with a qualifying diagnosis? The only thing the policy says is the life expectancy of each.

ANSWER: Medicare will only pay for one type of prosthesis at a time. Medicare will cover a different type of prosthesis if there is a change in the patient's medical condition. For example, if a patient receives a mastectomy form (L8001, L8002, L8015, L8020) post-operatively, a silicone prosthesis (L8030, L8031, L8035) would be covered when the patient's surgical site is healed and the patient is ready to use the more definitive prosthesis. Once the silicone prosthesis is provided, additional prostheses of any type would not be covered until the reasonable useful lifetime of the previous prosthesis is reached.

Rehab Equipment

No questions submitted.

Ostomy/Urological/Medical Supplies

15. We have patients who utilize foley catheter kits (A4311 and A4314). The patient requires additional catheters and insertion tray kits (A4311 and A4314) due to their specific medical condition. We bill these items on separate claim lines and indicate this information in the NTE segment of the electronic claim. However, during the past six months these claims have usually been denied. Prior to that, with the proper documentation in the NTE segment of the claim, they were covered. Upon telephone reopening request these are overturned two out of three times. Two of the telephone reopening line representatives indicate the narrative was included and adjust the claims for payment, one of the representatives indicates the claims cannot be adjusted because A4314 is included in A4311. What is the correct way to bill for the additional catheters and catheter kits?

ANSWER: Medicare covers no more than one catheter per month for routine catheter maintenance. Nonroutine catheter changes are covered with documentation that substantiates medical necessity, such as for the following indications:

- **Catheter is accidentally removed (e.g., pulled out by patient)**
- **Malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter)**
- **Catheter is obstructed by encrustation, mucous plug, blood clot**
- **History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month.**

The definition of HCPCS code A4311 is insertion tray without a drainage bag with an indwelling catheter. The definition of HCPCS code A4314 is insertion tray with drainage bag with an indwelling catheter.

The policy states that if a supplier bills for A4314 you should not bill A4311 at the same time as it is included in A4314. If the patient requires more than one indwelling catheter change per month and they also require a drainage bag, the supplier should bill multiple units of A4314 on the same line with the KX modifier. The KX modifier should only be appended to the claim if all documentation and coverage criteria as outlined in the medical policy have been met. Suppliers should also include the narrative explanation to indicate why more than one unit is required. For additional information regarding parameters for urological supplies please refer to the local coverage determination. If claim denial is received due to over utilization, a request for a Redetermination should be submitted along with all supporting documentation.

16. Claims are being audited back to January 2006 for urological supplies. Claims are being adjusted and money is being recouped indicating the patient was in a nursing home, hospitalized, in hospice, covered by a Medicare HMO plan, etc. We are not being notified in some instances until the money is recouped. In some cases the nursing home is closed and we cannot obtain the documentation to support our claim. Should suppliers receive a notice of the overpayment before the offset is taken?

ANSWER: When an overpayment is identified by the DME MAC or is done voluntarily by the supplier, a demand letter often referred to as a "refund request letter" will be sent to the supplier. This letter is generated when the Overpayment Recovery Unit performs an adjustment on previously paid claims to either deny or reduce the previous amount allowed. The demand letter is required by Medicare regardless of what entity identified the overpayment. The demand letter is the only form of notification a supplier will receive regarding a Medicare overpayment prior to claims being placed into offset. The Document Control Number (DCN) indicated on the letter will be used to track the overpayment and must be referenced with any communication (written or telephone) with the DME MAC regarding the specific overpayment.

The date of the demand letter depicts the start date of the 30-day time frame for interest accrual and the 40-day time frame to respond to the overpayment request prior to being placed into offset. The date of the demand letter also depicts the start date of the time frame in which a supplier has to submit a request for an appeal. Suppliers must file for a Redetermination if there is reason to believe the claim was denied in error and payment was recouped.

Note: All correspondence mailed from the DME MAC to any supplier will be mailed to the payee address on file with the National Supplier Clearinghouse.

Diabetic Monitoring and Supplies

17. Has CMS changed or amended its policy regarding the coverage of diabetes testing supplies that exceed basic utilization guidelines (one time per day for noninsulin treated, three times per

day for insulin treated)? We have received an inordinate amount of denials and requests for additional information on claims submitted on behalf of beneficiaries who are testing above the basic utilization guidelines. The Active LCD for Glucose Monitors (L27231) clearly outlines the documentation requirements for providing quantities of testing supplies that exceed these guidelines. We have always been diligent in obtaining all of the required documentation before dispensing supplies. We have followed up on these denials by filing re-determinations and reconsiderations, submitting all of the required documentation outlined in the LCD, including CMNs, beneficiaries' testing logs, physicians' progress notes, lab results, delivery tickets, proof of beneficiaries' requests for refills, etc., yet we continue to receive nonspecific CO50 denials ("These claims are noncovered services because this is not deemed a medical necessity by the payor.") We have searched for updates to this policy but have found nothing thus far. Additionally, several of our Medicare beneficiaries with diabetes have informed us that they have received phone calls from CMS telling them that Medicare will no longer pay for them to test above the basic utilization guidelines, which further leads us to question whether there has been a change in the policy. In summation, if we obtain all of the required documentation for over utilization set forth by the guidelines in the LCD for Glucose Monitors, how are we, as providers, supposed to deem whether the supplies are medically necessary, as there is no way to recoup our money after the supplies are sent out and the subsequent claim is denied for the reason mentioned above?

ANSWER: The Jurisdiction B DME MAC has conducted a widespread review of test strips and lancets. The primary focus has been on claims for noninsulin treated beneficiaries who are receiving supplies for testing more than once per day. Our review of the documentation that is submitted rarely supports the medical necessity for more frequent testing. This is consistent with an extensive review of the medical literature conducted by the DME MAC medical directors which found no clear evidence to justify testing more than once per day. When supplies in excess of one test per day are provided to noninsulin treated patients, it would be reasonable to obtain an Advance Beneficiary Notice (ABN).

Documentation/Regulatory/Miscellaneous/Other

18. Are there any regulations that prohibit a patient from completing paperwork via an electronic signature and date (i.e., wireless clipboard that UPS uses to obtain proof of delivery when a signature is required)? For our purposes, documents which contain a patient's signature include, but are not limited to, proof of delivery, AOB, ABN, acknowledgement of training, plan of care, confirmation of compliance with a piece of equipment, etc. Specifically, the Medicare Claims Processing Manual refers in more than one area that "this can be 'Signature on File' and/or a computer-generated signature."

ANSWER: The purpose of obtaining a "Signature on File" from the beneficiary is to save time and energy. To satisfy the requirements of Signature on File, the provider must maintain the original signature of the beneficiary in his or her records instead of getting the beneficiary's signature on every claim form. After getting the beneficiary's signature, the

provider can simply stamp the words, "Signature on File" in item 12 of the CMS-1500. The stamp may be used for assigned and non assigned claims. The beneficiary must sign a statement acknowledging that services were performed and authorizing that Medicare payments be made to the provider or to the beneficiary and allowing release of medical information. Medicare considers a legible identifier as one that is either hand written or electronic. Therefore, as long as the identifier meets these requirements and the signature can be identified as the beneficiary's and can be maintained in the supplier's records, it would be acceptable for the beneficiary to sign electronically.

19. The Q&A from the Medicare University 2009 Virtual Convention regarding Advance Beneficiary Notice of Noncoverage for DMEPOS Suppliers (200)
http://www.ngsmedicareconvention.com/q_and_a.html

Question #21 says:

Is the ABN used for Medicare beneficiaries only?
Yes. The ABN is for Medicare FFS beneficiaries only. The ABN is not used to identify items not covered by any other insurer or plan. However, for Medicare FFS beneficiaries, the ABN is required at the time an item is dispensed or delivered whether Medicare is the primary, secondary, or tertiary payer. Therefore, for example, if a beneficiary is currently employed and has GHP coverage through their employer and the GHP is primary to Medicare, the supplier must still issue an ABN if the supplier expects a medical necessity denial because Medicare is the secondary payer.
Our questions are:

a. Why does the answer state the ABN is for Medicare FFS beneficiaries only? It was our understanding that the Advantage Plans were supposed to follow Medicare guidelines. Some of the Advantage Plans require us to use the DME MAC CMNs.
ANSWER: The Medicare Advantage Plans (HMOs) must provide credible coverage, meaning they must cover the same items covered by Medicare FFS. However, their documentation requirements may vary. The ABN is specifically used by Medicare FFS. Suppliers must contact the HMO or Medicare Advantage Plan to determine whether or not advance beneficiary notice is required to hold the patient liable and, if so, how that notice should be completed/documented.
b. Is it violating any rule if we use the ABN for someone who is not a Medicare FFS beneficiary but is on a Medicare Advantage plan?
ANSWER: The ABN is to be used for Medicare beneficiaries only (including those who are dually-eligible for both Medicare and Medicaid). The ABN is not used for patients who are not Medicare beneficiaries.
c. Who is allowed to sign ABN? In the past we were instructed that only the patient or legal representative of the patient can sign, but the answer seems to indicate many more options.

ANSWER: The beneficiary or representative must sign the notice, with his or her own name, in the box simply labeled "Signature." The signature indicates that he or she has received the notice and understands its contents. A representative is defined in the Medicare Claims Processing Manual, Chapter 30, Section *50.4.3 as the following: Notifiers are responsible for determining who may act as a beneficiary's representative under applicable State or other law. A representative is an individual who may make health care and financial decisions on a beneficiary's behalf (e.g. the beneficiary's legal guardian or someone appointed according to a properly executed "durable medical power of attorney").* Other persons who may sign are *the* spouse, unless legally separated, an adult child, a parent, an adult sibling, a close friend "An adult who has exhibited special care/concern for the patient, who is familiar with the patient's personal values, and who is reasonably available."

20. What amount are we allowed to charge the beneficiary on an item with a properly executed ABN? For example, we charge $150 per month for E0601 CPAP and have an ABN signed because they did not meet the compliance requirements of Medicare. We accept assignment because they have a secondary policy that may cover the CPAP regardless of Medicare coverage. That the claim is denied/approved by secondary doesn't matter; Medicare denial does. Are we able to charge the patient the $150? Medicare denied it as not medically necessary PR-50. The Medicare Remittance Advice (RA) seems to indicate we may charge the full amount.

ANSWER: The amount that can be billed to the beneficiary will be indicated on the supplier's remittance advice following adjudication of the claim. The supplier may charge the beneficiary the amount indicated for the PR-50 denial (if denied as not medically necessary) or PR-96 (if denied as noncovered). If you are accepting assignment on the claim, you may only require the beneficiary to pay the 20 percent coinsurance, amount of any unpaid deductible and charges for noncovered items up front.

21. The Virtual Convention Q&A document for Top Claim Submission Errors and the CMS-1500 (08/05) Claim Form (200) session question #45 states the following: Can a physician's assistant be a referring physician? The answer indicates the following: Yes, however, come January 2, 2010, they will deny. Is this response accurate? I'm not sure where this is coming from. I haven't read anything about a change in their status. Is that for outpatient services? As far as I know, the Supplier Manual still refers to them as nonphysician practitioners.

ANSWER: The response provided was inaccurate and will be updated on the National Government Services Web site with the following:

Yes, a nonphysician practitioner may order or refer services. An ordering physician is a physician or, when appropriate, a nonphysician practitioner who orders nonphysician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for

nonphysician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non physician practitioner's service.

All claims for Medicare-covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name in item 17a and the National Provider Identifier (NPI) number in item 17b on the Form CMS 1500 or the electronic equivalent.

Physician and nonphysician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty eligible to order/refer services for Medicare beneficiaries. Please refer to Change Request (CR) 6417.

22. Will you please confirm that Medicare Part B does NOT cover E0637 Combination Sit to Stand system? Or can you point me to a resource on the NGS website that would confirm this? We need proof to provide to Illinois HFS (IDPA) for them to consider providing preauthorization for the product prior to delivery. They are under the impression that this is covered by Medicare and therefore will not provide preauthorization. I provided them with an EOMB (name blocked) from a 2008 claim denied with PR204. They won't accept this as proof. They informed us that they called to Medicare and were told that this is a covered item.

ANSWER: Yes, code E0637 is statutorily noncovered, no benefit category. This is a decision communicated to the DME contractors by CMS when the code was established in 2004. However, to the best of our knowledge, that determination is not published.

23. Is it acceptable medical documentation from a physician's office to use a checklist form on their letterhead for need of home medical equipment like hospital beds, wheelchairs and walkers? Also, we have hospitals that want to use an order set (checklist of medical need that applies) as their medical documentation for need of home medical equipment. Will this format of medical documentation support our claims in any audit (CERT, RAC, etc)?

ANSWER: No, checklists and similar documents will not be sufficient to support the medical necessity for DMEPOS items. Checklists can be used to identify that the beneficiary has no symptoms/complaints of a particular type or that the findings on physical examination are normal. However, any abnormality would need to be described in a narrative note by the physician.

24. From the January 2010 Q&A, Question 23: We often get an ABN when we think the patient may have had same/similar equipment before. However, they do qualify medically for the current walker, commode, whatever. We try to bill with a KXGA modifier combination, but these are

denying or rejecting. However, we believe it is perfectly legitimate to use both modifiers. How can we submit claims in this situation? Examples are available.

REVISED ANSWER: The LCD for most policies requiring the submission of the KX modifier clearly state in the "Documentation" section that suppliers must add the KX modifier to specific codes if all of the criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of the policy have been met. The GA modifier indicates the supplier believes the item they are billing is expected to be denied as not reasonable and necessary. Therefore, in most cases it would not be appropriate to append the GA and KX modifiers on the same claim line as they are contradictory.

However, for glucose testing supplies, the KX is used to indicate that the beneficiary is an insulin-dependent diabetic. Therefore, if the supplier believes the claim will be denied as not reasonable and necessary due to over utilization it would be appropriate to execute an ABN and append both the GA and KX modifiers. Another exception would be urological supplies where the KX modifier again is used to indicate the patient has a specific diagnosis (permanent urinary incontinence or urinary retention). Therefore, in the case of over utilization, it would be appropriate to execute an ABN and append both the GA and KX modifiers.

Medicare does not pay separately for backup equipment or items that are deemed to be same or similar to equipment that is already in use as they are considered not reasonable and necessary. If the supplier has evidence to believe that Medicare will not pay for an item because the patient already has or has had same/similar equipment, an ABN should be executed and the claim should be filed to Medicare with the GA modifier appended.

It would not be appropriate to append a KX and GA modifier to items like wheelchairs and hospital beds simply because you can't determine, or you think the beneficiary may have had or has same/similar equipment. This would be considered a blanket ABN.

Two follow up questions:

a. When did this change?
   ANSWER: This is not a change. Suppliers should never have issued an ABN simply because they "think" the patient may have or had same/similar equipment before. The ABN regulations from CMS state the following: ***50.8 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)*** *Notifiers must give an ABN when they expect Medicare to reduce the level of payment for an item or service because part of the item or service is not reasonable and necessary. For example, an ABN must be issued when a notifier expects a partial denial of a more extensive part of a usually covered item or service because that part is not reasonable and necessary. Examples of excess parts include increased charges attributable to furnishing something that is* ***more in number, more frequent****,*

given for a longer period of time, or that has added features or specific additional uses that are not medically necessary.)

b. How are suppliers to protect themselves when the patient has had the equipment before but has not disclosed the information to the provider?
ANSWER: The supplier has several options for determining whether or not the patient has had same/similar equipment before. Suppliers can check the Interactive Voice Response (IVR) System at 1-877-299-7900 or Claim Status Inquiry (CSI) to obtain this information. Suppliers should also ask the beneficiary questions during the intake process (i.e., have you ever been treated for this condition before, if so how long ago and how long, etc).

It seems clear from the CMS regulation that this is permissible. In this scenario, the patient does meet the medical necessity criteria (KX) but the supplier is not able to ascertain if the patient has had the equipment before and executes an ABN (GA). While in an upgrade situation from a full electric bed to the physician-ordered semi-bed, not putting the KX modifier with the GA on the full electric bed makes perfect sense. However, in the case of same or similar denials, it does not. The purpose of the ABN is to allow suppliers to protect themselves, yet we cannot use it? Please clarify.

ANSWER: It would not be appropriate to execute an ABN simply because you cannot ascertain if the patient has had the equipment before. You cannot execute an ABN simply because you think they might have had same/similar equipment before. If you determine the patient did have same/similar equipment and have reason to believe Medicare will deny the item you are billing, you should execute the ABN and append the GA modifier. You should not append the KX modifier because Medicare does not consider same/similar equipment reasonable and necessary.

25. We have a referral source who thinks that by enrolling in PECOS they are agreeing to be a participating physician with Medicare. They do not participate with Medicare and will not enroll until they have proof in writing that by enrolling they are not agreeing to participation. Can we get this answered in writing to provide to the physician's office?

ANSWER: All physician and nonphysician practitioners who wish to order or refer patients for items or services billed to Medicare must have a current enrollment record in PECOS. Otherwise, beginning January 3, 2011, the items or services will not be paid by Medicare. Participation and enrollment in PECOS are two totally separate issues. Physicians and nonphysician practitioners who enroll or update enrollment in PECOS have the option of either participating or not participating.

26. Medicare Learning Network Matters (MLN) Article 6359 titled Reporting the Beneficiary's Residence State Code and ZIP Code for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)claims states that beneficiary ZIPp codes will be required on claims

effective 07/01/2010. It was my understanding this was always the case. Is this a requirement for ZIP + 4? Or will the five-digit ZIP be sufficient?

ANSWER: Currently, suppliers are not required to enter the beneficiary's ZIP code + 4 on claims submitted to the DME MAC. The beneficiary's five-digit ZIP code is what should be reported on the claim submitted to Medicare. This MLN Matters Article just reiterates the importance of having the accurate address and ZIP code on the claim to allow for correct pricing when competitive bidding is fully implemented. Effective July 2010 the state and ZIP code will be sent to the Common Working File (CWF) for tracking and reporting purposes. In the past we looked at the state code and had limited system logic to look for the ZIP code. Claims submitted on or after July 6, 2010, without a five-digit ZIP code or state code will be denied with an ANSI-16. The claim will need to be corrected and resubmitted for payment.

27. When Medicare is secondary to a commercial insurance plan:

a. If the primary plan will pay MORE than Medicare allows for an item/code, does the mandatory claim filing rule still apply?
ANSWER: Yes, the supplier must submit the secondary claim to Medicare for the beneficiary in accordance with the mandatory claims filing requirements. Suppliers must file to the Medicare contractor all claims for services and supplies provided to Medicare beneficiaries, regardless of what the primary plan allows. When Medicare receives a claim as the secondary payer, Medicare's liability is the lower amount derived from three calculations. The first calculation determines how much Medicare would pay without regard to any primary insurer. The second calculation subtracts the primary insurer's payment from the higher of the Medicare allowance or primary insurer's allowance. The third calculation is the actual charge submitted by the supplier minus the primary payment.

b. Would we need an ABN signed by the beneficiary with Option 2 selected, in order to **not** have to file the claim?
ANSWER: No, you should not execute an ABN to avoid claim submission to Medicare just because you know the primary plan will allow more than Medicare. This would not be a valid reason to execute an ABN.

c. If our documentation indicates that the client does not meet Medicare coverage guidelines, do we need an ABN even if we expect more money from the primary insurer than Medicare would allow?
ANSWER: Yes, the ABN is mandatory for items that are expected to be denied as "not reasonable and necessary" pursuant to Section 1862(a)(1) of the Social Security Act.