

**Jurisdiction B Council A-Team Questions**  
**Sorted by A-Team**  
**January 21, 2010**

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**Home Medical Equipment**

1. Labor is paid by Medicare under the inexpensive routinely purchased payment category (IRP). Do suppliers need to obtain a signed rent/purchase agreement from the beneficiary for labor? Suppliers were informed by an independent consultant that a rent/purchase agreement is required for labor. Please verify so that suppliers are compliant in case of an audit (RAC, CERT, etc.).

**No, suppliers are not required to obtain a rent/purchase agreement for labor. Supplier standard number five indicates that a supplier must advise beneficiaries that they may either rent or purchase inexpensive or routinely purchased DME. Even though labor is paid under the IRP payment category it is not considered durable medical equipment and therefore the rent/purchase agreement is not required. For a listing of the supplier standards please refer to the National Supplier Clearinghouse Web site at: <http://palmettogba.com/palmetto/providers.nsf/DocsCatHome/National%20Supplier%20Clearinghouse>**

2. What initial date should be indicated on the Certificate of Medical Necessity (CMN) for the purchase of a TENS unit?

**The initial date for the purchase of the TENS unit reported in Section A of the CMS-848 Certificate of Medical Necessity Transcutaneous Electrical Nerve Stimulator should be a date on or after the date the patient was re-evaluated by the prescribing physician following the 30-day TENS trial period. The initial date should not be the same date that the TENS rental started.**

## Enteral/Parenteral/IV Therapy

No questions submitted.

## Respiratory Care Equipment/Oxygen Therapy

3. If a patient initially qualifies for PAP/RAD therapy (3-months), and for whatever reason they do not qualify for continued coverage (i.e., patient doesn't adhere to therapy, patient doesn't follow-up with physician, etc.) per the policy the patient is eligible to re-qualify for PAP/RAD but must have both a face-to-face re-evaluation with the treating physician and a repeat sleep study in a facility based setting. We are seeking clarification of these requirements as we feel they tax the Medicare program unnecessarily. If the original sleep study is sufficient for a patient becoming eligible to Medicare and the patient meets face-to-face and adherence requirements, why would a new sleep study be required for a patient who simply misses the adherence requirements by a couple of days. If a patient fails to show adherence or follow-up with the physician in the required time-frame, is a repeat sleep study required?

**If adherence to therapy, as defined in the PAP policy, is documented during the initial 12 week trial but the physician re-evaluation showing benefit is delayed until after the 91<sup>st</sup> day, continued use of the PAP device will be covered without the need for a repeat study. As specified in the LCD, in this situation, coverage would end on the 91<sup>st</sup> day and resume on the date of the late re-evaluation. However, if adherence to therapy is not documented during the initial 3 month trial, then a repeat sleep study, which must be a facility-based polysomnogram, is required before a new trial of PAP therapy would be covered. If the supplier, patient, and physician have been making appropriate efforts to improve a patient's compliance over a 3-month period without success, then a new evaluation would be reasonable to determine whether some clinical condition had been missed, however a repeat sleep study would still be required.**

4. Per policy, if a patient fails the initial 12-week trial period on a PAP device, a repeat sleep study is required. We have several patients who have failed the initial 12-week trial due to illness (i.e., sinus infection, cold, etc.) which interfered with their ability to use the PAP device as required. We also have patients who require mask changes, pressure changes, which often takes weeks to get the patient compliant. Once the patient becomes comfortable with the pressure or mask there isn't sufficient time left in the 12-week trial period to show compliance. If suppliers document these changes, along with physician recommendations is there a possibility that these claims can be reviewed for payment in lieu of the patient undergoing another sleep study? Patients and physicians question the need for another sleep study when they are now showing compliance.

**CMS has issued a directive that contractors may not make any exceptions to published LCDs.**

5. Does Medicare make any exceptions to the requirements discussed in questions 3 and 4? We have patients who are mentally challenged (i.e., Down Syndrome) who use the PAP device and benefit from it's use, but do not meet the adherence to therapy requirements outlined in the local coverage determination.

**If the patient is not using the device regularly, then he/she is not receiving full clinical benefit. The adherence requirement defined in the policy is not particularly rigorous. As noted above, exceptions to the LCDs are not possible at this time.**

6. A patient has an oxygen concentrator that has met the 36-month cap. The patient also uses a portable unit, which they received sometime after they received the concentrator. The portable unit is still being paid as a rental. Can the supplier be paid for the rental of the portable unit and also be paid for portable contents?

**Yes, if the patient began using portable gaseous or liquid oxygen equipment (E0431, E0434) more than one month after they began using the stationary oxygen equipment, monthly payments for portable gaseous or liquid contents (E0443, E0444) may begin following the stationary oxygen equipment payment cap and prior to the end of the portable equipment payment cap. Medicare would continue to pay the monthly rental of the portable equipment and portable contents until the 36-month cap for the portable equipment is met. After the 36-month cap is met Medicare will continue to make monthly payments for portable contents.**

**Suppliers are reminded that under no circumstances can they receive payment for the monthly stationary oxygen equipment and either stationary or portable contents. The monthly payment for stationary oxygen equipment includes payment for both stationary and portable oxygen contents.**

7. If a patient rents both a medically necessary concentrator and portable system and sometime prior to the end of the 36-month cap they no longer require the concentrator, but continue to require the portable system. Does Medicare pay for contents and portable equipment if the stationary equipment is no longer needed and has not met the 36-month cap? If so how do we get our claims paid?

**Yes, Medicare will allow for the payment of portable oxygen and contents if the patient no longer needs the stationary equipment and the cap for the stationary equipment has not been met. You will need to file a redetermination and request that the CMN for the stationary equipment be closed indicating it was returned. After the CMN file is updated you should be able to submit the claim for the rental of the portable and contents and receive payment.**

8. If a physician prescribes a quantity of inhalation medication greater than the quantity allowed by Medicare, can the supplier execute an Advance Beneficiary Notice (ABN) and charge the patient for the amount denied by Medicare?

**Yes, the purpose of the ABN is to inform the Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare certainly or probably will not pay for the item or service on that particular occasion. Claims submitted for Medicare covered drugs/biologicals are subject to mandatory assignment. If a supplier submits an unassigned claim for a drug or biological, the DME MAC will process the claim as though the supplier accepted assignment. Suppliers can collect unpaid deductible amounts, 20% coinsurance amounts, and the amount the beneficiary has agreed to pay because the amount of medication exceeds what is considered reasonable and necessary. It is recommended that suppliers wait until they receive the Electronic Remittance Advice/Standard Paper Remittance advice from Medicare before billing the patient.**

9. Has CMS provided clarification on what oxygen suppliers are supposed to do when they are replacing oxygen equipment after the RUL and a copy of the original delivery ticket for oxygen cannot be obtained from the previous supplier?

**No, National Government Services has not received any additional information regarding this issue. As is the case for all DME items, suppliers must maintain proof-of-delivery documentation in their files for replacement oxygen equipment. (See Section 5.8 of Chapter 5 of the *Program Integrity Manual* (Pub. 100-08)). In addition, for equipment that is being replaced because it has been in continuous use by the beneficiary for the reasonable useful lifetime and the beneficiary has elected to obtain new equipment, the supplier must also have proof-of-delivery documentation in their files for the item being replaced that documents that the oxygen equipment has been in use for at least 5 years.**

10. These questions are in reference to the requirement in the PAP LCD which indicates physicians interpreting facility-based polysomnograms must now meet the credentialing requirements effective January 1, 2010. In the past Medicare has stated there is no time limit or expiration for a sleep study (e.g., a sleep study that was performed in 2007 could be used to qualify a PAP patient).
  - a. For a new PAP set up on or after January 1, 2010, does the supplier need to make sure that the facility-based sleep study used to qualify the patient was interpreted by a duly-credentialed physician?

**The PAP LCD has been revised to state: "For PAP devices with coverage based on a facility-based polysomnogram (Type I) performed on or after January 1, 2010, the interpreting physician must meet one of the requirements listed above (1-4)**

**for credentialing.” For polysomnograms performed after that date, the supplier should determine whether the interpreting physician meets the requirement.**

- b. If this information cannot be verified or the physician was not duly-credentialed during that time frame but is credentialed now do we need to ask the patient to have a repeat sleep study in order to qualify?

**Yes**

- c. Is it okay to execute an ABN if the supplier cannot ascertain that the physician who interpreted the sleep study was duly-credentialed?

**Yes**

- d. How can a DMEPOS supplier determine if the physician is appropriately credentialed?

**or You can request that the physician or sleep lab provide information about their credentials. A list of diplomats of the American Board of Sleep Medicine can be found on their web site – [www.absm.org](http://www.absm.org). For physicians certified in Sleep Medicine by other boards, you can also register through the American Board of Medical Specialties web site ([www.abms.org](http://www.abms.org)) for access to a database which has information about physician credentials.**

- e. What kind of documentation will a DME supplier be required to present for an audit to show the physician was appropriately credentialed when the sleep study was interpreted?

**Suppliers should maintain a copy of the physician’s credentials or a copy of printout from the American Board of Medical Specialties (ABMS )Web site.**

- f. If the physician was credentialed when the sleep study was interpreted but later loses those credentials, does that impact future claims for PAP and/or PAP supplies?

**Ongoing rental and/or PAP supplies for devices whose coverage is based on a sleep study that was interpreted while the physician was credentialed will continue to be covered.**

#### **Prosthetics/Orthotics**

**No questions submitted.**

## Rehab Equipment

11. If we provided a K0011 in 2003 that currently requires repair what HCPCS should be indicated in the NTE segment of the electronic claim to inform Medicare about what is being repaired?

**Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. For patient owned equipment, in addition to the above information, all of the following must be submitted in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims.**

- **HCPCS code of base equipment**
- **Make, Manufacturer and Model number of equipment if applicable**
- **A notation that this equipment is beneficiary-owned and**
- **the date the patient obtained the equipment**

**Example: Pt owned K0011 Electric Mobility Viva Rascal 081507**

12. With the new DPD requirements what should be listed on the DPD when a patient receives an upgrade? Prior to the DPD change Jurisdiction B posted the following: “the upgraded item does not need to be listed on the DPD. Only the wheelchair base ordered by the treating physician that the patient meets medical necessity for is required to be on the DPD.” If a patient is receiving an update and only the medically necessary item is to be listed, does the DME MAC want the provider to list their “Medicare chair” from the category that the patient meets the need for or do you want to know what chair is being delivered/provided to the patient and allow the claims processing requirements to reflect what chair is being paid for?
  - a. If a Medicare beneficiary qualifies for a PWC (K0822), but would like a K0856, what should be indicated on the detailed written order?
    - i. K0822, description of a K0822, Provider Charge for K0822 and allowable for K0822
    - ii. K0822, description of K0856(item received), Provider Charge for the PWC receiving (K0856) and allowable for K0822
    - iii. K0856, description of K0856 (item received), Provider Charge for the K0856 and allowable for K0856
    - iv. K0856, description of K0856 (item received), Provider Charge for the K0856 and allowable for K0822

**The requirement is for a DPD that is based on the chair that will be covered by Medicare (i.e., in the example provided: K0822, description of K0822, Provider Charge for a K0822, and allowable for K0822). For the physicians benefit, it may be helpful for the provider to also provide information about the PWC that will actually be provided.**

13. If we provide a tilt option (E1002) and the patient does not qualify, but the patient opts to receive the tilt option. Should the tilt option be included on the detailed written order? The reason clarification is needed is if the supplier puts the tilt option on the detailed written order, but the patient doesn't qualify the physician may think Medicare will pay. Should the detailed written order indicate the patient requests the item but does not meet Medicare coverage requirements? Should the detailed written order include what is provided or what the patient qualifies for?

**If the physician didn't think that a tilt was necessary, then you do not need to include it on the detailed written order. In that situation, the EY modifier must be appended to the HCPCS code when submitted to Medicare.**

14. If the physician refers the patient to an LCMP for a mobility evaluation does the physician's note need to clearly state that the major reason for the visit was for a mobility evaluation or is the requirement satisfied if the LCMP evaluation clearly states that the patient is at the therapy evaluation for a mobility evaluation since the face-to-face examination is a process whereby the documentation is taken in it's entirety?

**In the scenario that is described, although the detailed information would be in the LCMP's report, the physician note should indicate that there was discussion of mobility issues and that a referral was being made.**

15. With the new DPD requirements how is a provider expected to manage a change in equipment provided based on the final delivery? For example, a small chest harness is required. The medium chest harness is required. The medium chest harness will have a different part number from what is listed on the DPD. What is the compliant way to manage this situation?

**There should be a thorough assessment of the patient before a DPD is prepared. If there is a change in the patient's condition between the time that the DPD is prepared and the date of delivery, then according to the LCD, a new DPD for that accessory would have to be signed and dated by the treating physician before delivery of that item.**

16. With manual WC bases K0001-K009 + E1161: can we bill separately when added to the initial WC for these codes?: E2211 pneumatic propulsion tire, E2212 tube for pneumatic propulsion tire, E2213 flat free insert for propulsion tire, E2214 pneumatic caster tire, E2215 tube for pneumatic caster, E2216 foam filled propulsion tire, E2217 foam filled caster tire, E2218 foam propulsion tire, and E2219 foam caster tire? The options/accessories chart is not clear. If we would bill for the K0070, K0071 and/or K0072 (all 'complete' wheel assemblies), then these tire codes are included. These would be billed only on repairs, as the wheel assembly is included on the initial chair. But since

we would not be billing the K0070/K0071/K0072 on the initial chair, the specific codes for the non-standard/non-solid tires are not specifically included. And these are generally upcharges on the chairs (solid tires, standard, are included; variations of pneumatic tires are not included). If these codes are expected to be included with the base, why are they not listed just like the solid tire codes E2220 - E2225? (some of these are also included with K0069). The logic is not consistent... Please clarify.

**According to the bundling table in the Wheelchair Options and Accessories Policy Article, the nine E codes listed in the question would be eligible for separate billing/payment with the initial issue of a manual wheelchair.**

17. If a beneficiary owns a manual wheelchair but now is in need of a power wheelchair due to a change in medical condition, should suppliers append the RA modifier to the HCPCS code of the power wheelchair and include reasonable useful lifetime (RUL) information in the NTE segment of the claim for the power wheelchair? The power wheelchair is not being dispensed because of loss, damage or irreparable repair. What specifications should the NTE segment include?

**No, the RA modifier should not be appended. If the patient started using a manual wheelchair but due to medical necessity changes required a power wheelchair, and all coverage criteria have been met, Medicare will allow for the payment of a power wheelchair. You are not required to indicate anything in the NTE segment of the claim in the scenario described above, but you are not prohibited from including information regarding the patient's change in condition which warrants the need for a power wheelchair. If a same/similar denial is received suppliers should request a redetermination with all of the supporting documentation.**

18. The face-to-face date on the PMD RX has the following exception stated in the LCD: If the physician saw the patient to begin the examination before referring the patient to an LCMP, then if the physician sees the patient again in-person after receiving the report of the LCMP examination, the 45-day period begins on the date of the second physician visit. However, it is also acceptable for the physician to review the written report on the LCMP examination, to sign and date the report and to state concurrence or any disagreement with that examination. In this situation the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed and dated copy of the LCMP examination to the supplier. The 45-day period begins when the physician signs and dates the LCMP examination.

If the LCMP has not listed all options and accessories for the PMD on the initial evaluation report, and additions are made prior to the chair being delivered – the physician must review and attest to the revised evaluation with the additional medical



necessity information. If the physician does so, does the new signature date then become the official face-to-face date for counting the 45 and 120 day timelines?

**The face-to-face examination just deals with the need for the base equipment - e.g., POV, power wheelchair. Any further evaluation relating to options and accessories does not re-set the 45 or 120 day time frames.**

### **Ostomy/Urological/Medical Supplies**

19. Syringes used for administering medication are they considered non-covered? If “ yes”, is it in writing that they are non-covered? If patient is receiving enteral supplies, can these be included in price of enteral feeding kit?

**Syringes used solely for the administration of medication through an enteral feeding tube are noncovered, no benefit category. We are not aware of that being specified in writing. (Note: It is impossible to specifically list every item that is not covered by Medicare.) Noncovered items should not be included in the submitted charge for the enteral feeding kit.**

20. We have a Medicare Beneficiary that is using A5120 with his urological supplies. On Wednesday, February 01, 2006 I received a list-serve message titled: **Incorrect Billing of HCPCS Code A5120—REVISED**, the message states *Suppliers should continue to bill HCPCS code A5120 when used with both urological and ostomy. The claim should only be submitted with the AU modifier when furnished in conjunction with urological supplies and/or ostomy supplies.* The current Medical Policy does not mention A5120, so could you please let me know if this still holds true? Provider Service line said that since A5120 is not in the policy it is not covered under the urological policy. Response from Nina Gregory: I do believe this is a non-covered service since they are skin barrier wipes A5120 SKIN BARRIER, WIPES OR SWABS, EACH

**The current Urological Supplies Policy Article states that the AU modifier may only be used with three codes (A4217, A4450, and A4452) when supplies are used to treat permanent urinary incontinence. Therefore, AU should not be added to A5120 if it is used in conjunction with urological supplies.**

### **Diabetic Monitoring and Supplies**

No questions submitted.

### **Documentation/Regulatory/Miscellaneous/Other**

21. If a claim is inadvertently submitted without the appropriate KX, GA, GZ or GY modifiers will the claim reject on the front end? If not, and the claim is denied, a list serv of 7/30/09 indicates the claim should be resubmitted with appropriate modifiers.

Will this process correctly because technically it is a different code due to modifier or will it deny as a duplicate? How are these to be handled?

**Suppliers will receive a rejection from the DME MACs if a claim is submitted and does not include the appropriate KX, GA, GZ or GY modifier as specified in the LCDs. If a claim line is rejected, the supplier must resubmit the claim with the appropriate modifier, the claim will not be denied as a duplicate.**

22. For a written order prior to delivery (WOPD), what elements must be on the WOPD for dispensing? IE, item, diagnosis, length of need, etc?

**Written orders prior to delivery should have all of the elements described in the section on Detailed Written Orders in Chapter 8 of the Jurisdiction B Supplier Manual, which can be located at:**

**<http://www.ngsmedicare.com/content.aspx?CatID=3&DOCID=233>**

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.

**The LCD for all policies requiring the submission of the KX modifier clearly states 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. A claim should never be submitted with both a KX and GA modifier on the same claim line. 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. If you have evidence to believe that Medicare will not pay for an item because the patient already has a same/similar item then an ABN should be executed and the claim should be billed to Medicare with the GA modifier. An ABN should not be executed simply because the supplier thinks the patient may have had same/similar equipment before. If you have all of the required medical documentation outlined in the LCD then the claim should be submitted with the KX modifier. National Government Services will review claim examples once provided.**

24. K0462 is for rental of equipment while a customer owned item is being repaired. I can't find any actual policy that spells out how to bill for K0462; I know we have had several questions answered about this in the past (but those documents are no longer posted on the website). I know we should bill the K0462 on the same claim as the repairs. In the

narrative for the K0462, we should enter the code of the item we provided as a rental, which should generally be the same code as the item we are repairing - correct? For example, if we are doing an involved repair on a bed, we would put code E0260 in the narrative, and the expected payment would be the allowable for an E0260.

**The temporary loaner equipment (K0462) must be submitted on the same claim as the claim for repairs (labor and parts). The date of service should be the date the loaner equipment is delivered to the patient. The following information must be included in Item 19 on the CMS-1500 paper claim form or in the NTE segment for electronic claims:**

- the manufacturer and brand name/number of the item being repaired,
- the manufacturer and brand name/number of the loaner equipment,
- a detailed description of what was repaired
- a brief explanation of why the repair took longer than one day

If we are repairing a complex wheelchair, and provide an equivalent rental, there are actually a lot of billing codes involved. If the customer needs a power wheelchair with tilt, and we provide them with a power chair with tilt to use while we are fixing theirs: would we put multiple codes in the narrative - K0856 + E1002 +???; and then would the allowable be based on the combined fees for the package?

**Medicare will pay for temporary loaner equipment based on medical need as long as the rental of the loaner for one month and repair charges does not exceed the purchase price of a new piece of equipment.**

Also, are there any particular documentation requirements for the temporary rental, besides a signed delivery ticket? Do we need an prescription that specifies a temporary rental in addition to a prescription for the repairs?

**No, you would not need a new prescription. The claim would be billed with code K0462 with a narrative indicating the reason why loaner equipment was required. Suppliers would only receive one-month rental payment for the loaner equipment. Suppliers are reminded that detailed records describing the nature of the repair and justification for the temporary replacement of the item should be maintained.**