Jurisdiction B Council Follow-Up
Questions and Answers
Sorted by A-Team
January 13, 2011

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Follow up Questions for Jurisdiction B Council Meeting January 13, 2011

Medicare Competitive Bid

1. For a beneficiary who has a permanent residence in a non-competitive bid zip code and rents a PWC starting after January 1, 2011:

Scenario # 1: They are visiting a CBA during the rental period.
Scenario # 2: They move to a permanent residence in a CBA zip code during the rental period.

a. Is the beneficiary required to obtain their PWC from a contract supplier, under the competitive bidding or traveling beneficiary rules, or do they continue renting from a non-contract supplier?

ANSWER:
Scenario #1: In this situation, since the beneficiary is not obtaining new equipment while in the CBA s/he is visiting, the non-contract supplier may continue to provide the power wheelchair while the beneficiary is visiting the CBA.

Scenario #2: In this situation, since the beneficiary is moving in the CBA, s/he will need to obtain a power wheelchair from a contract supplier. The grandfathering provision only applies to those items that were rented by the beneficiary prior to the implementation of the Competitive Bidding Program (CBP). In order to continue receiving the service from the non-contract supplier, the beneficiary was required to be renting the power wheelchair on December 31, 2010.

b. If they continue can renting from the original supplier, and the area where the beneficiary moves, visits or travels to is outside of the service area for the supplier: is the supplier permitted to pick up their power wheelchair or is the supplier required to allow the beneficiary to take it beyond their service area?

ANSWER:
Scenario #1: If the beneficiary is only visiting the CBA, the non-contract supplier should work with the beneficiary as they would if competitive bidding were not at issue.

Scenario #2: If the beneficiary relocates permanently to the CBA, the non-contract supplier must pick up its equipment, as the grandfathering provision does not apply as the rental period began after the start of the CBP.

c. If the supplier picks up their chair and suspends or terminates rental billing for the PWC does the beneficiary have the option to purchase the power wheelchair from a contract supplier in the CB area where they move, are visiting or have traveled to?

ANSWER:
Scenario #1: If the beneficiary is only visiting the CBA, the non-contract supplier should work with the beneficiary as they would if competitive bidding were not at issue.

Scenario #2: Yes, in this situation, the beneficiary has the option to rent or purchase a power wheelchair from a contract supplier in the CBA.

d. If the beneficiary has the option, or is required to receive their power wheelchair from a contract supplier in the area they move to, are visiting or have traveled to is a new face-to-face examination, 7 element order, detailed product description and home evaluation required for the contract supplier to compliantly append the KX modifier and bill for the power wheelchair?

ANSWER: If the beneficiary elects to obtain equipment from a contract supplier, a new face-to-face examination, 7 element order, detailed product description and home evaluation do not need to be performed as these criteria were met with the original qualification for the power wheelchair. However, the new contract supplier needs to obtain copies of these items for its files. If copies cannot be obtained, new documents may need to be obtained as established under DME MAC guidelines.

e. If the bene does obtain a new power wheelchair from a contract supplier, is there any reduction in payment to the contract suppliers because of earlier rental payments to the original supplier?

ANSWER: No, a reduction in payment is not assessed to the new contract supplier. The beneficiary receives a new rental period and/or may accept to purchase the power wheelchair under competitive bidding guidelines

f. If medical necessity is presumed to continue and the contract supplier is not required to meet the statutory requirements to append the KX modifier and bill for the PWC what documentation must they make available to CMS or one of their contractors in the event of an audit?

ANSWER: The new contract supplier needs to obtain copies of the medical documentation for its files. If copies cannot be obtained, new documents may need to be obtained as established under DME MAC guidelines. Please keep in mind the CBP does not change the documentation requirements of the DME MACs.

2. The beneficiary has a POA who is registered with the SS Office, and who resides in a CBA. The beneficiary actually resides outside of any CBA. Can the local (non-CBA/non-contract) supplier bill for this patient and continue to be reimbursed at 'normal' Medicare fee schedule amounts? Is any special indicator needed on the claim(s)?

ANSWER: The example provided indicated the beneficiary is living in Murray, Kentucky and the POA resides in Cincinnati. In this situation, you would file the claim with the KT modifier for the services provided to the beneficiary in the non-CBA.

3. Oxygen patients, not living in a CBA and/or for dates of service prior to 01/01/11; who have oxygen claims denied for lack of CB modifier, CO-4 Denials. Example will be given to Charity via fax.

ANSWER: Council did not provide claim examples for research.

4. What type of documentation is needed in case there is an audit on repair versus replacement items?

ANSWER: You should document what base equipment is being repaired, why it needs repair, why replacement of the part is needed, and any other information specified by the DME MAC. For items that are normally replaced due to wear (e.g., power wheelchair batteries, tires, wheelchair cushions, or walker tips), these items should not be furnished by a non-contract supplier unless there is an acute identifiable incident causing damage. You should document the incident causing the damage (e.g., power surge, perforated tire, etc.).

Standard Power Wheelchairs – elimination of 1st month purchase option

5. If Medicare is the secondary payer for a K0823 power wheelchair, which is purchased by the primary payer, and the beneficiary meets the Medicare coverage criteria for the PWC, will Medicare pay up to the "purchase" allowable of $3637.93, the capped rental total of $3819.83 or does

the beneficiary no longer have payment benefits for a PWC in this scenario due to the mandatory rental of these items?

a. If payment benefits remain, how should this be billed?
b. If payment benefits are not available to the beneficiary is it permissible for the supplier to execute an ABN for a PR denial?

ANSWER: Effective January 1, 2011 DMEPOS suppliers that provide standard power-driven wheelchairs (K0813-K0831, and K0898) may no longer offer the beneficiary the option of purchasing the power mobility device at the time it is delivered due to these items now fall under the Capped Rental payment rules. Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

If a primary insurance pays for the lump sum purchase of an item that Medicare will only pay for as a rental, Medicare cannot make a secondary payment. Medicare would not make a primary payment; therefore, a secondary payment could not be made for the lump sum purchasing of such a item.

It is not appropriate to execute an ABN in this instance. The claim will deny as a CO-108 (rent/purchase guidelines were not met).

6. If a rental power wheelchair is denied for payment in a pre-pay audit, or it is denied and payment is recouped in a post-pay audit, is it permissible for the provider to pick up the power wheelchair, obtain the necessary documentation, re-deliver, and submit a new claim beginning in month 1 as no payment has been made and same/similar equipment would not be on file?

ANSWER: Suppliers should be utilizing the Advance Determination of Medicare Coverage (ADMC) process for power wheelchairs (PWCs). This process will allow the supplier to submit all supporting documentation to Medicare prior to dispensing the item. This will allow the supplier to have a pre-determination on the Medicare coverage criteria prior to dispensing. In the instance where a supplier receives a denial from the ADMC, an Advance Beneficiary Notice of Noncoverage (ABN) should be properly executed (prior to delivery) in order to advise the beneficiary of their financial liability. "For additional information on ADMCs and which HCPCS codes are eligible for ADMCs, please refer to Chapter 9 of the Jurisdiction B DME MAC supplier manual." In instances where the supplier delivered the PWC and did not execute an ABN, any denials given by Medicare will fall to the supplier's responsibility.

When Medicare denies the claim, it is advising that Medicare will not make payment on the item that was dispensed due to the Medicare coverage criteria was not met. Suppliers should work with the ordering physician to obtain additional medical records to support the coverage criteria. Suppliers who receive denials on their claims should follow the appeals process in order to submit the documentation the supports the Medicare coverage criteria.

When a supplier receives a denial and is held liable, the effect of the denial cancels the sale/rental agreement the supplier has with the beneficiary. The supplier must refund all of the rental payments received from Medicare and refund the beneficiary, if applicable, within 30 days of the remittance notice. The beneficiary must return the equipment to the supplier if the item is resalable or re-rentable. When the contract of sale or rental is cancelled, whether or not the supplier physically repossesses the resaleable or re-rentable item, the supplier may enter into a new sale or rental transaction with the beneficiary with respect to that item as long as the beneficiary has been informed of their liability by signing an ABN.

7. On the detailed product description (DPD) for a capped rental K0823 power wheelchair should the "Medicare Fee Schedule Allowance" be listed as $545.69 (allowable for the 1st 3 months), $3637.93 (purchase allowable per CMS formula) or $3819.83 (total rental allowables for 13 month)?

ANSWER:
Two of the required elements of the Detailed Product Description (DPD) are the supplier's submitted charge and the Medicare fee schedule allowance. Medicare fee schedule allowances typically change with a new calendar year and may be revised at other times.

- **If the supplier's submitted charge and fee schedule allowance are correct at the time that the DPD is signed by the physician but change prior to delivery of the Power Mobility Device (PMD), the supplier is not required to obtain a new DPD.**

- **If the DPD was completed in 2010 based on the submitted charge and fee schedule allowance for a purchased PMD, a new DPD is not required if the PMD is delivered in 2011 and billed as a rental.**

- **Suppliers should report either the applicable monthly submitted charge and fee schedule allowance or the combined total submitted charge for all thirteen months of rental and the combined total fee schedule allowance for all thirteen months of rental.**

8. For a break in billing of a capped rental power wheelchair, such as an extended hospital admission, the 11/11/10 FAQ on power wheelchair rentals states "if the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the beneficiary is in their 4-13th month of rental would the new DPD for the K0823 list $218.28 (rental allowable for months 4 – 13), $545.69 (rental allowable for months 1 – 3), $3637.93 (Purchase allowable per CMS formula) or $3819.83 (total of 13 months rental allowables) as the "Medicare Fee Schedule Allowance"?

ANSWER: If there is an interruption in monthly billings/Part B payments during the period of continuous use, but the medical need for the equipment continues (e.g., Part B payments stop

while the beneficiary uses equipment during an institutional stay), a new capped rental period does not begin when the patient is discharged from the inpatient facility and resumes use of the supplier's equipment. This type of interruption does not entitle the beneficiary to begin a new capped rental period—regardless of the length of the interruption. The supplier may not submit another claim until the beneficiary is discharged from the inpatient stay and use of the supplier's equipment resumes. National Government Services refers to this situation as a break in billing. If a break in billing occurs the supplier is not required to obtain new medical necessity documentation. However, specifically for the PMD policy a detailed product description (DPD) is required when a change in equipment occurs. Therefore, in the scenario described above a new DPD would be required. In regards to the monthly submitted charge and fee schedule allowance that must be reported please refer to the response provided for question.

Least Costly Alternative

9. With the elimination of the least costly alternative/ down-coding being removed from 25 LCDs the council request clarification on the following:

a. We can provide a free upgrade item to a patient and bill the prescribed item using the GL modifier. What information must be indicated in Item 19 or the NTE segment?

ANSWER: DMEPOS suppliers have the option to provide upgraded items at no additional charge to the beneficiary. The supplier would submit one claim line with a GL modifier appended to the HCPCS code that describes the item that is covered based on the LCD. In this situation, the supplier does not bill the HCPCS code that describes the item that was actually provided.

Example:

Line 1: HCPCS K0001RRKHKXGL Submitted amount: $165.00

Item 19 or the NTE segment: Specific make and model of the item actually furnished (the upgrade item) and the reason behind the upgrade.

b. If the beneficiary requests an upgraded item, can we bill for the standard equipment prescribed and request that the patient pay the difference between the upgraded item and the standard item?

ANSWER: Yes, suppliers must bill two line items for upgraded DMEPOS items where the beneficiary requests an upgrade. Suppliers must bill both lines on the same claim in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item the supplier actually provided to the beneficiary with the dollar amount of the upgraded item. If the supplier has a properly

obtained ABN on file signed by the beneficiary, use modifier GA. If the supplier does not have a properly executed ABN on file signed by the beneficiary, use modifier GZ.

Line 2: Bill the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item. Use modifier GK.

Suppliers should bill their full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the reasonable and necessary item (Line 2).

c. The physician prescribed an item the patient does not meet coverage criteria for (i.e., K0007 - heavy duty wheelchair), however the patient does not meet the 300 lb weight requirement for the heavy duty wheelchair because they only weigh 280 lbs. Can an item be considered an upgrade even if the item is physician ordered?

ANSWER: Yes, an item can be considered an upgrade even if the physician signed an order for it. Refer to the response provided in question 8b.

10. 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: National Government Services is currently seeking clarification on this question and provide a response once received.

11. 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 Grp 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 Grp 4 base.

ANSWER: This question has been submitted to the four DME medical directors for a response.

Other

12. RA/RB modifiers: There are new 'definitions' of replacement parts vs repair parts and the use of RA/RB modifiers in the Competitive Bid DME Repairs and Replacements Fact Sheet; do these same definitions and usage for RA/RB 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 replacement submitted by DMEPOS suppliers regardless of whether the beneficiary resides in a CBA.

13. With the addition of competitive bid modifiers please explain the sequence modifiers must be appended to the HCPCS code.

ANSWER: The primary pricing modifiers (NU, RR, UE) must be appended to the HCPCS code in the first position, any additional applicable pricing modifiers (KE, KG, KK, KU, KW, KY) should be appended in the second position followed by any applicable primary capped rental modifiers (KH, KI, KJ, MS) in the third position, followed by any additional applicable capped rental modifiers (BU, BR, BP) and then any applicable informational modifiers (KX, KL, KV, KT, J4, RA, RB, etc). An E-mail update was sent out on Friday, February 4, 2011 titled "Modifier Billing Reminders" and provides detailed instructions on modifier sequence. This article is also posted on the National Government Services Web site, and will be included in the March edition of the Jurisdiction B Connections as well as the revised version of the Jurisdiction B Supplier Manual.

PAP policy follow-up:

14. If patient elects to change to contract supplier after 1/1/11 what documentation is required?

a. New 12 week trial?
b. compliance download
c. face to face re-evaluation
d. What modifiers on the claims?
e. Do we need to go to break in service to extend CMN?
f. What will CERT look for in post pay audit?

ANSWER: For this question they aren't saying in what month the patient wants to switch to a new supplier. The documentation requirements would not change due to competitive bid. They would need a new order (due to switching suppliers). They can provide some supplier prepared statement indicating when the change occurred but the same documentation would be required (with the exception of a new order) as if the patient had always been with that company. A new 12 week trial period would not start over due to a switch in suppliers. They would just need to show based on the month the patient is in that they meet initial coverage

criteria and if beyond the 4th and subsequent months that they meet continued coverage criteria. If the patient failed the compliance, switching to a new supplier does not change the requirements and they will still need a new qualifying type I sleep study and physician re-evaluation before the 4th and subsequent months will be covered by Medicare. Break in service/need requirements would not apply because a break in need lasting 60 + days did not occur.

15. PMD policy – can the home evaluation be done by a subcontractor?

ANSWER: Yes, as long as the Competitive Bid contracted supplier understands that they are ultimately responsible for the quality of care and service the subcontractors is providing.

16. Manual Wheelchair - Coverage Criteria Physician Documentation Requirements Letter: Could this be re-looked at – policy does not require face to face but this implies.

ANSWER: The following language is in the manual wheelchair – coverage criteria and physician documentation letter posted on the National Government Services Web site. Council indicated they believe this gives the impression that a face to face evaluation is required. Council asked if this language could be clarified.

Yes, the "Dear Physician" letter will be updated to the following:
The medical necessity for the wheelchair must be clearly documented in the patient's medical records. The records could include your office notes, hospital records (e.g., operative note or discharge summary), or the records of other healthcare professionals (e.g., physical therapist or occupational therapist). The records must indicate the diagnoses that are related to the need for the wheelchair and pertinent history including: symptoms that limit ambulation, progression of the disease and ambulatory difficulty over time, experience with a cane or walker and why it isn't sufficient. It should specifically describe how far the patient is able to ambulate without stopping and with what assistive device. Furthermore, it should clearly describe the patient's physical condition, including (as applicable): leg strength, range of motion, presence of contracture or spasticity, balance and coordination, cardiopulmonary exam, etc. The medical record should also include a documented observation of ambulation with use of a cane or walker, if appropriate. Simply listing this information on the order or on a form provided by the supplier is not sufficient. It must be documented in the patient's medical records.

17. Electronic Signatures – Council is requesting further education on these for compliance purposes. What is allowed and what is not?

ANSWER: The following are some guidelines developed by National Government Services A/B Medical Review staff concerning electronic signatures.

Acceptable electronic signature examples:

- **Notation of electronic signature;**
- **Signature on file at electronic location;**
- **Notation that document created by treating/ordering/rendering provider;**
    - **Electronically signed by,**
    - **Authenticated by,**
    - **Approved by,**
    - **Completed by,**
    - **Finalized by,**
    - **Signed by,**
    - **Digitally signed by,**
    - **Validated by**
    - **Authenticated by,**
    - **Sealed by,**
    - **List is not all inclusive**
    - **Notation that the document was dictated by treating/ordering/rendering provider;**
    - **notation that the document was "dictated by"**
    - **a transcription notation, (e.g. GNC/cng)**

Note: A typed signature, without indication that the document was dictated by treating/ordering/rendering provider, is not acceptable, even if typed on letterhead.

18. Electronic prescribing: specifically, one new program that is being promoted is www.pmdrx.com. Would Dr Brennan be willing to review and comment? (Not endorse… just asking for a general comment on whether this could be an appropriate way of collecting medical necessity documentation.)

ANSWER: Dr. Brennan asked if Council could provide examples of documentation created utilizing this electronic prescribing software. Council will see if they can obtain some examples and forward them to me for Dr. Brenann and the other DMDs to review.