National Government Services

A CMS Contracted Agent

medicare university

Jurisdiction B Council A-Team Questions
Sorted by A-Team
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Enteral/Parenteral/IV Therapy

1. **We have learned that Abbott Nutrition U.S. will be exiting the enteral tube feeding device business in the U.S. and Puerto Rico on April 30, 2013. According to an announcement posted on the Abbott Nutrition U.S. website (http://abbottnutrition.com/et/enteral-transition.aspx?s=nutrition-innovation), it appears that this specifically includes all pumps, disposable sets, tubes, kits, and related device accessories.**

   We seek guidance on behalf of Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers who are currently providing Enteral Feeding Supply Kits; pump fed (B4035), that contain an Abbott pump administration set. All Abbott enteral pumps use a dedicated set manufactured solely by Abbott, which will no longer be available starting April 30, 2013. Our understanding is that there are no national, or local policies from CMS regarding the replacement of an enteral pump that is no longer available, nor a policy to replace a pump when the administration sets for that pump are no longer available from any manufacturer.

   Specifically, the questions are:

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a. **What is the process that a Medicare DMEPOS supplier should follow to replace an enteral pump that a beneficiary owns when they can no longer access the dedicated pump set manufactured by Abbott?**
b. **What is the policy on replacing an enteral pump when the one in place is no longer available in the market?**

Answer: There is no process that allows Medicare reimbursement for replacement of a pump for the reason noted. Enteral pumps are either purchased on a lump sum basis or rented. Regardless of whether the pump is rented or purchased, the standard repair/replacement rules apply (replace if lost, stolen, or irreparably damaged). Replacement upon reaching the useful life of the pump is also allowed; however, this is considered eight (8) years for enteral and parenteral pumps. There is no scenario where the supplier may receive payment from Medicare due to the discontinuation of equipment by the manufacturer.

Respiratory Care Equipment/Oxygen Therapy

2. **We understand that contents are included in the payment allowance during the 36-month rental period for a stationary gaseous or liquid oxygen system. Our question is in reference to oxygen fills after the 36th month rental cap. The oxygen billing requirements for oxygen contents were changed in 2006 per Change Request (CR) 4271 from actual oxygen units to one unit equal to one month of service. This applies to healthcare common procedure coding system (HCPCS) codes E0441 through E0444.**

   Since Medicare pays for a flat rate equivalent to one unit regardless of the amount provided, is there a need for a durable medical equipment (DME) provider to document (for audit purposes) the actual weight of liquid oxygen on every delivery?

   Answer: There is no requirement that the supplier document the actual weight of the liquid oxygen delivered. Prior to delivery, the supplier should assess the quantity that the beneficiary still has remaining and ensure the quantity the supplier delivers is sufficient to last the beneficiary for the one-month, two-month, or three-month period for which they are billing. To satisfy proof-of-delivery requirements, it is sufficient to indicate the quantity of tanks delivered.

3. **Patient is requesting a continuous positive airway pressure (CPAP) mask that is expensive and does not provide any additional benefit. Patient wants the mask, tubing, and headgear on the same day. Can I bill non-assigned for mask but bill assigned for**

other supplies on the same day. If not, are there options for an advance beneficiary notice of noncoverage (ABN) upgrade when the item is the same HCPC as basic item and does not have any additional features?

Answer: No. A supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. Per the Internet-Only Manual (IOM) 100-04 Claims Processing Manual, Chapter 1, Section 30.3.2, "*A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating physician/supplier does not accept assignment, and is also not precluded from billing the patient for services that are not covered by Medicare. However, a physician/supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a physician/supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. When a carrier becomes aware that a physician/supplier is fragmenting his/her bills, it must inform him/her that this practice is unacceptable and that he/she must either accept assignment for, or bill the enrollee for, all services performed at the same place and on the same occasion.*"

4. **What are patient's options when their oxygen is no longer covered due to being denied in a Medicare audit from a technicality such as being seen by a physician 32 days prior to being set up on O2... they are still in need of their oxygen yet it is not covered?**

   Answer: The Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment states that the beneficiary must be seen and evaluated by their treating physician within 30 days of the initial date of service and that the qualifying test results must be done within 30 days before the initial date of service. Therefore, in the situation described, the beneficiary will need to be seen and evaluated by their treating physician and undergo another blood gas study. If the beneficiary still qualifies, the oxygen must be set up within 30 days of the treating physician's visit.

5. **A patient is prescribed oxygen at 5 liters per minute (lpm) with a portable. The patient is mobile within the home and qualifies at rest on room air; however, when the patient in tested on 4 lpm, they do not qualify. I know we will not get paid the higher allowable but will we get paid the normal allowable on both the concentrator and the portable?**
   Answer: If coverage criteria are met, a portable oxygen system is usually payable separately in addition to the stationary system. However, if the prescribed oxygen amount

is greater than four lpm, portable oxygen is *not* separately payable as payment for the portable equipment is included in the higher allowance for the stationary equipment. In the situation described, although the beneficiary is prescribed a higher liter flow, they do not qualify and are not receiving the higher liter flow. Therefore, the QF or QG modifiers should not be appended. The supplier will not receive the higher payment amount but will receive payment for the stationary and portable equipment provided the CMN is properly completed and the modifiers (when applicable) are properly submitted. Proper use of the QF and QG modifiers will insure proper payment. For billing guidance, refer to the article titled, "*Reminder: Revised High Liter Flow Oxygen and Oxygen Equipment Payment and Billing Guidelines*," located on the National Government Services Web site Policy Education page.

6. **Certified Nurse Practitioners (CNPs) working in collaboration with physicians are eligible to bill Medicare Part B under their individual national provider identifier (NPI) numbers for current procedural technology (CPT) codes 94760, 94761 and 94762. When CNPs perform and bill oximetry testing for Medicare beneficiaries in a skilled nursing facility (SNF) in anticipation of discharge to home, is this testing an acceptable method to qualify a beneficiary for the home oxygen benefit?**
   Answer: An independent physician or qualified entity testing beneficiaries that is not an employee of the supplier or facility could provide the service if all other coverage criteria requirements are met. Medicare requires that testing for oxygen qualification be performed by a qualified provider of lab services.

7. **If a patient is admitted to the emergency department diagnosed with pneumonia and the physician wants him discharged home with oxygen (w/qualifying lab results) would this be covered? If not, when would oxygen testing from an emergency room visit be acceptable?**

   Answer: No. Medicare requires testing be done while the patient is in the chronic stable state. Testing obtained in any setting while the patient is acutely ill does not meet that requirement and cannot be used for oxygen qualification.

8. **The inconsistencies and the appearance of changing the rules as we go through the oxygen audits has been a challenge. We wonder why there is still a very high prepay audit % on oxygen. Would National Government Services reveal the thresholds that have been established to determine when to remove it from 100% prepay?**

   Answer: Medicare payment policy has not changed. It is true that the number of reviews has increased and the emphasis has shifted to a comprehensive assessment rather than

selected criteria. Error rates remain high because overall supplier compliance with all of the required criteria remains low. At this time there is no end date on the oxygen audits. There continues to be several suppliers that remain on the oxygen audits due to their denial percentages. National Government Services is not auditing 100% of oxygen claims and has removed several suppliers. The parameters used to determine removal from the audit cannot be reproduced by the supplier community therefore at this time they will remain unpublished.

9. **Our company is noticing the following issues. Please advise.**

   a. **All Categories: We are seeing use of the American National Standards Institute (ANSI) CO-96 denial for long-term care (LTC) admissions again. Is this a system issue?**
   b. **All Categories: We are getting OA 109 denials and when we check thru the Common Working File (CWF) eligibility (ELGB) lookup and Zirmed there is no LTC stay on file. The patient's address is correct in our system. When we call, the provider contact center (PCC), they can see the dates. Why can't we?**
   c. **Respiratory/oxygen (O2): We are getting CO -173 and CO-176 denials. When we reflag the Certificates of Medical Necessity (CMN) to transmit electronically and resubmit the claims we are getting OA-18 denials. When we call customer service they tell us to do exactly what we have already done. Has policy changed on these denials? Requested examples.**

   Answer: Awaiting claim examples. Without examples we are unable to answer questions (a-c) at this time.

10. **Patient received a CPAP machine on 10/24/11 by private insurance. Medicare became the primary insurance on 06/01/2012. The patient was noncompliant with CPAP due to intolerance which was documented in a 07/17/2012 office note. On 09/06/12 the patient had only a bi-level positive airway pressure (BIPAP) device titration and interface fit was documented. Would this suffice to dispense a BIPAP machine, or would the patient need to have a diagnostic since Medicare has never been billed?**

    Answer: Per the LCD, if an E0601 device has been used for more than 3 months and the beneficiary is switched to an E0470, a new initial face-to-face clinical evaluation is required, but a new sleep test is not required. A new 3-month trial would begin for use of the E0470. In the scenario above the patient was on CPAP from 6/1/12 – 9/6/12 before being switched to a bi-level device.

Rehab Equipment

11. **If a capped rental item is in the middle of a capped rental period and the beneficiary is moving out of state or outside of a provider's existing service area, can the supplier pick up the equipment?**

    Answer: Yes. The beneficiary may rent equipment from a different supplier in the vicinity of their new residence. A new capped rental period does not begin in this situation.

    a. **Does the supplier have an obligation to set the patient up with a new supplier for the remainder of the rental period?**

       Answer: No.

    b. **Must the original supplier continue to provide the equipment and contract with the local supplier to maintain the equipment?**

       Answer: No.

    c. **In the case where the capped rental item is a power mobility device (PMD), if the supplier is allowed to pick up the rental equipment, or the beneficiary elects to transfer to another supplier we understand that a new rental episode does not begin; however, is a new face-to-face exam, 7 element order, detailed product description (DPD) and home assessment required to be on file for the new supplier to begin billing?**

       Answer: The new supplier must obtain a new 7-element order, a new detailed product description, a home assessment, and a new proof-of-delivery. The supplier should request all required documentation that supports medical necessity from the previous supplier or the physician so that it is available in the event the supplier's claim is audited at a later date.

       In situations where a PMD prior authorization demonstration applies, the new supplier must submit a prior authorization request and include a copy of the new 7-element order, new product description, new proof of delivery, a copy of the original affirmed prior authorization letter, and a note indicating that the request is due to the beneficiary transferring to a new supplier.

12. If a beneficiary rented a standard power wheelchair (K0823) for 5 months and informs the supplier that they now want to purchase the chair outright, is it appropriate to execute an ABN informing the beneficiary that are fully financially responsible and that Medicare will not make any payment toward the purchase of the chair? In addition, if the power wheelchair (PWC) becomes beneficiary-owned in this manner will Medicare reimburse for medically necessary repairs?

Answer: Effective January, 1, 2011, standard power-driven wheelchairs (K0813-K0831, and K0898) must be billed to Medicare under the capped rental item guidelines. Standard power wheelchairs, including K0823, are no longer eligible for the purchase option – even if the beneficiary requests to purchase the item. (However, an exception applies for suppliers that are **contract suppliers** under Round One Rebid Competitive Bidding Program. For these suppliers payment for standard power-driven wheelchairs will **continue** to be allowed on either a lump-sum purchase or rental basis for qualified Medicare beneficiaries who live in a Competitive Bid Area [CBA].) If a claim for one of these items is billed to Medicare as a purchase, the claim will be denied CO-108, and the supplier will be held liable. Liability may not be shifted to the beneficiary.

An ABN would not be appropriate in the scenario described above as an ABN will only protect the supplier from liability in the following situations:

- Services not reasonable and necessary
- Violation of the prohibition on unsolicited telephone contacts
- Supplier's supplier number requirements are not met
- Advance determination of Medicare coverage (ADMC) denial
- Noncontract suppliers providing a competitively bid item to a beneficiary in a CBA

Medicare does cover necessary repairs to beneficiary-owned equipment, or equipment for which the title has transferred to the beneficiary, which is not covered by the manufacturer's warranty.

13. We are hearing reports of ADMC denials as well as claims denials for an expandable controller (E2377) and the necessary wiring harness (E2313) when used to control a power tilt feature and power elevating leg rests. The reference cited for the denial is the Power Wheelchair Electronics Clarification, which was revised 4/29/11. In review of this document, the wheelchair options LCD, and the wheelchair options policy article there is no definitive guidance on the correct coding/billing of these two codes when power

elevated leg rests (ELR) or a power articulating foot platform (AFP) is used in combination with power tilt and/or power recline system without shear reduction.

Can you please review and confirm that E1002 and E1010, E1003 and E1010, and E1004 and E1010 all have 3 actuators/motors and that one unit of E2377 and one unit of E2313 are allowed as this is the only way, electronically, that power elevating leg rests can operate. Without an expandable controller (E2377) and wiring harness (E2313) a beneficiary would only be able to operate the right OR the left elevating leg rest with the power tilt or recline feature, not both. If they needed to operate both the right AND the left leg rest then they would not be able to operate the power tilt or recline feature. The system cannot communicate the commands to all three actuators/motors with a non-expandable controller.

Answer: An expandable controller (E2377) and wiring harness (E2313) are eligible for payment when necessary to operate three (3) or more actuators/motors.

14. **For PMDs, if an addendum or correction is made to a 7 element order or part of the face to face evaluation, would that necessitate changing the date of the face to face on the seven element order?**

Answer: Corrections and amendments are addressed in CMS Program Integrity Manual (PIM) 3.3.2.5. The heart of this section says that records may be corrected if errors were made or that additional information about the already-completed examination is needed for clarification. When changes to the record are made for such a correction or addition, a change to the face-to-face (F2F) date is not necessary, since all information arises from the already-completed F2F examination. New information acquired outside of or in addition to the already-completed F2F exam, however, changes the date used for the F2F exam to the date that the ordering physician incorporates the new information into the F2F. If the date of the F2F changes, all requirements that are linked to the F2F are affected (F2F date on the seven-element order (7EO), 45-day document delivery requirement, 120-day product delivery date, completion date of the DPD, etc.). As the F2F date changes, these other items may be impacted as well.

From a document review perspective, the core issue is to identify when a change to the F2F represents a simple correction or addition to the already-created examination vs. the addition of new information aside from the already-created exam. Obviously this assessment rests upon the quality of the information provided by the person making the correction or amendment in identifying clearly the nature and source of the added

information. CMS gives reviewers some latitude to make judgments but the instructions clearly tell us that inference is never a substitute for incomplete, unclear or confusing records.

The durable medical equipment Medicare administrative contractors (DME MAC) continually recommend to all suppliers that they work closely with their referring physicians so that they are familiar with the relevant reimbursement policy requirements and provide the most clear and complete discussion in the medical record showing that the applicable policy criteria are met. The power mobility device (PMD) prior authorization request (PAR) provides an additional opportunity for suppliers to enhance this interaction with feedback describing the identified deficiencies. National Government Services simply reminds you of the need to clearly distinguish between which amendments require a change in F2F date and which do not.

15. **A supplier received an order for a wheelchair cushion system for a patient who has Down's syndrome, scoliosis, and dementia. Unfortunately none of these diagnoses are in the LCD for positioning backs or cushions. The physician who ordered the system will not enter 331.0 Alzheimer's as a diagnosis (which is listed in the seating LCD) because he states "you cannot diagnose Alzheimer's until the person has died as you need to do an autopsy on the brain to accurately diagnose this." The supplier has all the medical documentation to support the medical necessity. Will these types of claims always have to be taken to review just because a diagnosis code is not specifically listed in the LCD?**

    Answer: Yes, at this time if the provider is unable to use one of the listed diagnoses in the LCD then at redetermination, a request for "individual consideration" could be made. It is important to remember that dementia has numerous causes with Alzheimer's being only one type. It is incorrect to code all dementias with the International Classification of Diseases, ninth revision (ICD-9) for Alzheimer's disease.

16. **Can the DPD and the 7-element order be signed on the same date by the physician?**

    Answer: Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This could occur on the same day as long as the 7-element order is received first so the appropriate PMD can be determined. The DPD cannot be prepared by the supplier until the supplier has obtained

the 7-element order and has completed their assessment determining which items are necessary.

Ostomy/Urological/Medical Supplies

17. Two 4x4 (A6402) sponges are included in the tracheostomy care kit (A4629). Can a patient receive additional sponges with supporting documentation of copious secretions? If so, what modifier(s) would need to be appended to the claim line?

Answer: Sponges are included in the allowance of the tracheostomy care kit under the Tracheostomy Care Supplies LCD. If the patient has excess respiratory secretions, look to the Suction Pump LCD for possible coverage. If coverage cannot be met under the Suction Pump LCD, there is no benefit for dressings or anything else for "excess secretions." Coverage might be met under the Surgical Dressings LCD if another co-existing condition meets the surgical dressing benefit (e.g., debriding Pseudomonas infection).

18. According to the recent Surgical Dressing – Benefit Category Reminder that was posted, it states:

> **"Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound… Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings."**
>
> **There are many occasions when a patient requires a primary dressing such as a wound filler, gauze pad soaked in saline, Dakins, oil emulsion dressing, to name a few, that require a secondary dressing to cover, and then tape to secure. Tape alone would not secure the moistened gauze or an oil emulsion pad. If wound filler is used, a dressing would be required to cover the wound and absorb drainage. Some patients require a gauze roll secured with tape to cover a dressing if their skin is fragile and tape can't be used directly on the skin. Would tape be covered in these situations or would we need to obtain an ABN?**

Answer: Per the Surgical Dressing LCD, tape is covered when needed to hold on a wound cover, elastic roll gauze or non-elastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented. Tape change is determined by the frequency of change of the wound cover. The types of dressings you are referring to do not include an adhesive border.

Documentation/Regulatory/Miscellaneous/Other

19. **If a registered nurse (RN) charts O2 sat testing on room air and the patient qualifies on ambulation but the nurse forgets to write the third test result, can she go back to the note and add it within a reasonable timeframe (i.e. 30 days) and if so, would the DME MACs accept the addendum so long as the physician signs off on the entry?**

    Answer: As stated above in #14 related to PMD orders, corrections and amendments are addressed in CMS PIM 3.3.2.5. The heart of this section says that records may be corrected if errors were made or that additional information about the already-completed examination is needed for clarification. Obviously this assessment rests upon the quality of the information provided by the person making the correction or amendment in identifying clearly the nature and source of the added information. CMS gives reviewers some latitude to make judgments but the instructions clearly tell us that inference is never a substitute for incomplete, unclear or confusing records.

    The DME MACs continually recommend to all suppliers that they work closely with their referring physicians so that they are familiar with the relevant reimbursement policy requirements and provide the most clear and complete discussion in the medical record showing that the applicable policy criteria are met.

20. **How should a provider address physician amendments to medical records? We frequently see that physicians add extra information to an existing record and notate it as an addendum but we are concerned about how the DME MACs would address such an addition in an audit.**

    Answer: Refer to question #19.

21. **Will the DME MACs accept an addendum made to a medical record from a physician and if so, is there a timeframe in which the addendums must be completed?**

    Answer: The DME MACs will accept appropriately amended records as described in the CMS Program Integrity Manual, publication 100-8, Chapter 3, Section 3.3.2.5. Providers are encouraged to enter all relevant documents and entries into the medical record at the time they are rendering the service. Occasionally, upon review a provider may discover that certain entries, related to actions that were actually performed at the time of service but not properly documented, need to be amended, corrected, or entered after rendering the service.

22. **Medicare requests the date the patient purchased the patient owned equipment. If the patient cannot recall the exact day but knows the month and year, can we use the 1st or last day of the month? If not, how do we resolve?**

    Answer: If the beneficiary is unsure of the exact date, an approximate date is sufficient.

23. **Where can we get clarification on guidelines for "CMN ONLY" appeals that we send to have the CMN/DIF loaded? Exactly when is it acceptable to send CMN ONLY to reopening?**

    Answer: All supplier requests to have CMNs/DIFs loaded should be submitted as Redetermination requests and must include a properly completed CMN/DIF. Although submitted as a Redetermination, when the sole purpose of the redetermination request is to load a CMN/DIF, the request is processed as a reopening. This type of redetermination request should occur on a very limited basis as suppliers should have software in place that is capable of submitting the CMN and/or DIF when required.

24. **If an additional documentation request (ADR) is received for an oxygen patient who was restarted after 5 years, what documentation is required to be submitted?**

    Answer: If a claim for the rental of the replacement equipment (following the reasonable useful lifetime [RUL]) is selected for review, the reviewer may request a copy of the dispensing order, the detailed written order and/or CMN, qualifying test results supporting information on CMN (new testing is not required for replacement of equipment), documentation of continuing use and documentation of continuing need. When responding to a request for documentation, the supplier should carefully review the ADR letter to determine the documentation being requested by the reviewer. The supplier must submit all documentation requested for review.

25. **We received call from a customer that needed a replacement walker (RUL) that Medicare had paid for. In this situation would we need a dispensing order or would it be sufficient that the order was placed by the customer and then we send a detailed written order to be signed? Do you need a dispensing order for replacement equipment or can customer call in the order?**
    Answer: A new order (and/or Certificate of Medical Necessity [CMN] when required), is needed to reaffirm the medical necessity of the item for replacement of an item. In the situation described above, upon receipt of the beneficiary's call requesting a replacement

walker, and prior to dispensing the walker, the supplier should contact the beneficiary's treating physician to obtain an order or ask the beneficiary to contact their treating physician to obtain an order. The supplier must have an order prior to dispensing and a detailed written order prior to billing. The detailed written order will satisfy both requirements if received by the supplier prior to dispensing.

26. Regarding Medicare Learning Network Matters (MLN) Matters #MM8009, where do providers obtain information on Medicare beneficiaries that will inform us as to the "legal" status of that beneficiary? It is unrealistic to expect suppliers to know that a beneficiary is "illegal" if Medicare and the social security administration recognize them as being eligible at the time supplies and equipment are dispensed.

Answer: Aliens, who are not "qualified aliens", are prohibited from receiving Federal benefits, including Medicare benefits. Medicare is prohibited from making payment for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service. The supplier's process for making this determination is a business decision made by the supplier.

27. Please clarify the expectation regarding the billing date when an item is delivered to a beneficiary prior to discharge from a facility. Per policy:

> ***Items Provided in Anticipation of Discharge from a Hospital or Skilled Nursing Facility***
> ***Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and shall use the place of service (POS) code 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.***

The policy is very clear – bill the DME with the discharge date. However, at recent NGS workshops, NGS staff specifically told providers to bill with the day AFTER discharge as the date of service. This is contrary to the policy quoted above. This may be due to

edits that sometimes cause claim denials if the discharge date and the DME delivery date are the same. Please clarify which date should be used on claims.

Answer: The date the beneficiary is discharged from the inpatient admission should be reported as the date of service on the supplier's claim.