

Jurisdiction B Council A-Team Questions Sorted by A-Team July 15, 2010

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Enteral/Parenteral/IV Therapy

1. We have patients receiving home infusion therapy and require multiple medications. We are required to bill for denial on the infusion therapy drugs and supplies not paid by Medicare before we can submit claims to secondary insurance. The secondary will pay for both therapies under their per diem billing contract. However, when we submit the claim to Medicare we are required to bill with the assigned HCPCS codes. The problem is we receive duplicate denials. How can we bill these claims to Medicare and receive a Patient Responsibility (PR) denial?

ANSWER: Requested examples of claims that had been denied incorrectly by Jurisdiction B. Examples were not available. Once examples are received, further research will be completed and a response will be provided.

Respiratory Care Equipment/Oxygen Therapy

2. If a patient has been on a CPAP for greater than 3 months (beyond 12-week trial) and they now have a prescription for a BIPAP. What documentation is needed for the patient to qualify for the BIPAP?

The new PAP policy states if an E0601 device has been used for more than 3 months and the patient is switched to an E0470, a new initial face-to-face clinical evaluation is required, but a new sleep study is not required. A new 3 month trial would begin for use of the E0470. Ineffective is defined as documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings).

Do the four new criteria need to be documented by the physician in the above scenario, or is this only during the titration or failure during the 12-week trial period?

1. Tried and unsuccessful with attempts to use the E0601,
2. Multiple interfaces tried and current interface is appropriate,
3. Work of exhalation with current pressure setting of the E0601 prevents the beneficiary from tolerating therapy; and
4. Lower pressure settings of the E0601 fail to adequately control the symptoms of OSA.

ANSWER: Whenever a patient with OSA is switched from a CPAP to bi-level PAP there must be a new order and there must be documentation that the CPAP was ineffective. Documentation that the CPAP was ineffective would include the four elements from the Documentation Requirements section of the LCD that are listed. In addition, if the patient has been on CPAP for more than 3 months, there must be a face-to-face visit with the physician.

3. An oxygen customer is past the 36-month cap and has private insurance as primary to Medicare that does not cap oxygen payments at 36-months. Is the beneficiary liable for the primary insurance co-payment amounts during months 37-60? We have submitted claims to Medicare for months 37-60 for MSP purposes only, the EOBs from the primary show that the primary allowed payment or in some cases payment was applied to the beneficiary's primary insurance deductible. Regardless, Medicare is denying these MSP claims with a CO-A1, which does not permit us to bill the beneficiary. Furthermore, DMEPOS suppliers are not permitted to waive co-pay or deductible amounts on a routine basis. Is this denial correct? What should suppliers do in this situation?

ANSWER: The Medicare Secondary Payer Manual, 100-05 does not clearly answer this question. Therefore, this question has been forwarded to CMS for a response.

4. The PAP policy indicates that adherence to therapy is defined as use of the PAP device \geq hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first 3-months of initial usage. If a beneficiary has a report with a date range greater than 30 days (i.e., 93 days), but the report does not show 30 consecutive days. Is it appropriate to use this report if it indicates the beneficiary used the PAP device \geq 4 hours per night on 70% percent during the 93 day period?

ANSWER: Yes, as long as the time period of the report represents consecutive days and the time period is at least 30 days and all of the days in the reported time period are within the first 3 months of use. The report would have to show use for at least 4 hours on 70% of the nights in the reported time period – e.g., on at least 65 nights if the reported time period was 93 days.

5. Masks and headgear come packaged together and the headgear is designed specifically for a specific style of mask by the manufacturer. If a beneficiary needs to change masks within 6-months due to fitting issues, can the corresponding headgear for that particular mask be billed as well, even if it is sooner than the 6-month frequency parameter in the medical policy?

ANSWER: Yes – but there must be clear documentation of the need to switch the interface.

6. We have a PAP compliance/adherence report which provides 210 days worth of data. The report does not provide a separate breakdown with details on each nights use during the 210 day total; however, it does provide a grand total of more than 70% during those days. Is this an acceptable compliance report or not, considering we cannot prove that out of the 210 days there were 30-consecutive days when the PAP device was used 70% of the nights \geq 4 hours per night?

ANSWER: That would not be acceptable. First, the report does not identify usage specifically during the 3 month trial period. Also, it appears that the report shows % of the total hours rather than specifically identifying nights with at least 4 hours of use.

Prosthetics/Orthotics

7. The following clarification is requested by the Jurisdiction D DAC O&P A Team relating to the 2010 Update on the Knee Policy which states the following: “For codes L1832, L1843, L1845 and L1850, knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).

Claims for L1832, L1843, L1845 or L1850 will be denied as not medically necessary when the patient does not meet the above criteria for coverage. For example, they will be denied if only pain or a subjective description of joint instability is documented”

The following tests and maneuvers can be performed by licensed practitioners to detect specific problems within the knee joint. While any one test may not be diagnostic of a particular problem, by performing a good knee examination most common knee problems can be properly diagnosed.

Would the following objective tests for evaluating knee problems ALL be considered as valid objective measurements of knee instability which if positive, would provide adequate documentation of joint laxity supporting the medical necessity for a knee orthosis?

Tests to Detect a Meniscus Tear

Joint Line Tenderness Joint line tenderness is a very non-specific test for a meniscus tear. The area of the meniscus is felt, and a positive test is considered when there is pain over the area where the meniscus is found.

McMurray's Test McMurray's test is performed with the patient lying flat (non-weight bearing) and the examiner bending the knee. A click is felt over the meniscus tear as the knee is brought from full flexion to 90 degrees of flexion.

Ege's Test Ege's test is a specific maneuver to detect a meniscus tear. With a patient squatting, an audible and palpable click is heard/felt over the area of the meniscus tear. The patient's feet are turned outwards to detect a medial meniscus tear, and turned inwards to detect a lateral meniscus tear.

Tests to Detect Ligament Injury

Lachman Test The Lachman test is the best test to diagnose an ACL tear. With the patient lying flat and relaxed, the examiner bend the knee slightly, about 20 degrees. The examiner then stabilizes the thigh while pulling the shin forward. Both the amount of translation (shifting) as well as the feel of the endpoint offer information about the ACL.

Anterior Drawer Test The anterior drawer test is also performed with the patient lying flat. The knee is bent 90 degrees and the shin is pulled forward to check the stability of the ACL. An intact ACL will only allow the shin to come forward slightly. A torn ACL will allow the shin to move further forward.

Pivot Shift Test The pivot shift test is a difficult maneuver to perform on a patient who is not under anesthesia. This test places a stress on the knee joint that forces a subluxation (partial dislocation) in patients who do not have an ACL. This test recreates the type of instability that caused the ACL injury.

Posterior Drawer Test The posterior drawer is performed similarly to the anterior drawer test. This test detects injury to the PCL. By pushing the shin backward, the integrity of the PCL is tested. Excessive movement of the shin backwards is a sign of PCL injury.

Varus and Valgus Instability Varus and valgus instability tests check the LCL and MCL, respectively. With the patient lying flat, and the knee held at about 30 degrees of flexion, the shin is shifted to each side. Insufficiency of the LCL or MCL will allow the knee to "open up" excessively. The test is repeated with the leg straight. If the knee still opens up excessively, then more than just the LCL or MCL was torn.

Varus Stress Test The varus stress test is slightly more difficult to perform than the valgus test because the table begins to get in the way of performing the test correctly. For this reason, the

patient's thigh is placed slightly more away from the table (abducted) and one hand is placed with the thumb stabilizing the lower extremity and the fingers or thumb placed directly over the lateral jointline. In this position, the amount of joint line opening that occurs can be palpated. It is important that this hand also serve to stabilize the extremity such that true amount of instability can be felt. The other hand is placed over the patient's foot and is used to apply varus stress with the knee flexed at 30°. Increased varus opening is assessed and compared to the normal contralateral knee. Mild (0-5mm), Moderate (5-10mm), or severe (>10mm) lateral compartment opening, compared to the normal knee is usually indicative of at least a posterolateral knee injury and potentially an ACL and/or PCL injury.

Dial Test The dial test checks the rotation allowed at the knee joint. Patients who have posterolateral rotatory instability, may have excessive rotation at the knee joint. The test is done with the patient lying face down, and the knees bent about 30 degrees. The feet are turned outwards and compared to each other. Excessive rotation is a sign of posterolateral corner injury.

External Rotation Recurvatum Test (Hughston Test) With a slight downward pressure to the femur, the great toe is lifted and the amount of recurvatum (hyperextension) of the knee is assessed.

Failed Total Knee Arthroplasty Test Documentation of failed recovery post total knee arthroplasty. Affected leg quadriceps weakness documentation (e.g., quadriceps circumference variance affected vs. non-affected leg).

Neurologically Impaired Gait Test For MS, Hemiplegia, unspecified, Cerebral Palsy, Paraplegia of both lower limbs and Mononeuritis of lower limb, unspecified documentation of gait abnormality must be documented (e.g., Hemiplegic gait with circumduction of the lower leg during gait).

If any of the above mentioned are not adequate documentation of knee instability, please provide examples of what would be considered as objective descriptions of joint laxity for each of the above listed medical conditions that are listed as qualifying for a knee brace under existing Medicare policy.

ANSWER: As the tests are described above, the tests from the Lachman Test through the Dial Test would provide an objective description of joint laxity.

Rehab Equipment

No questions submitted.

Ostomy/Urological/Medical Supplies

No questions submitted.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

8. With regard to the items listed on the Assignment of Benefits (AOB), how much detail is required? If the AOB lists "enteral nutrition therapy and supplies" is this specific enough or, does the AOB need to have the actual enteral feeding formula (e.g., Jevity, Fibersource, etc.)? If the actual enteral feeding formula must be listed, is a new AOB required each time the formula changes? Likewise, is "chemotherapy and supplies" sufficient, or do suppliers need to list the actual chemotherapeutic agent (i.e., Fluorouracil) ambulatory infusion pump, catheter maintenance supplies, and supplies for drug infusion pump?

ANSWER: The Internet Only Manual (IOM) does not specifically address this question, therefore the question has been forwarded to CMS for a response.

9. If the delivery ticket is more than one page, does the beneficiary or beneficiary representative need to sign each page? If the delivery ticket indicates page 1 of X does the beneficiary need to sign each page?

- **ANSWER: There are no specific requirements related to multiple page delivery tickets in the Internet Only Manuals (IOM). Therefore, this question has been forwarded to CMS for clarification.**

10. If a beneficiary's medical record ID number is on the delivery ticket/AOB, does the form also need to include the beneficiary's HICN number? If the HICN number is required, are the last 4-digits acceptable rather than the entire HICN number?

ANSWER: The delivery ticket and AOB must clearly identify the beneficiary. However, the beneficiary's HICN is not required on either form.

11. Is it acceptable for the beneficiary to give the supplier 'permission to leave' (PTL) the items being delivered if they will not be home? In this case, the delivery ticket would not be signed by the beneficiary upon delivery. The signature line on the delivery ticket would indicate PTL and the supplier representative delivering the items would sign and date the delivery ticket attesting to the fact the items were left.

ANSWER: No, it would not be acceptable to indicate (PTL) on the delivery ticket and have the supplier representative sign and date the delivery ticket. However, if the supplier uses an independent delivery service (e.g., UPS, FedEx) the beneficiary/designee would not have to sign as long as there was a tracking slip from the delivery service verifying that the package was delivered.

When delivering an item directly to the beneficiary by the supplier, it is recommended that proof of delivery be documented by a delivery ticket, signed and dated by the beneficiary or his or her designee. For the purposes of delivery tickets a designee is defined as “any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary,” however, suppliers or anyone else having a financial interest in the delivery of an item are prohibited from signing the delivery ticket.

The delivery ticket must be signed on the date the item or service was delivered. The delivery ticket should include the following:

- The beneficiary’s name
- The date the items were delivered
- The quantity of items delivered; and
- A detailed description of items including brand name and serial number if applicable.

12. Is it acceptable for the detailed written order to indicate ‘replacement supplies as needed’ or does the detailed written order actually need to indicate, for example, ‘PAP tubing 1 every 3-months’?

ANSWER: “As needed” by itself is not sufficient. “1 per 3 months, as needed” is acceptable.

13. Does the reasonable useful lifetime of used equipment fall under the five year rule? This could have major implications under the new Medicare legislation.

ANSWER: Yes, if a Medicare beneficiary opts to purchase for example a used Power Operated Vehicle, Medicare will not pay for a replacement POV until it has met the reasonable useful lifetime expectation of 5-years unless it is lost, stolen or irreparably damaged.