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

1. **We submitted a claim for bi-lateral elevating leg rests (E0990). We billed one claim line, with two units of service, with modifiers NUKEKX99. We also provided a narrative explanation in the note (NTE) segment "Rpl E0990 BBR PO E1161 DOP 11062007 MCR PD". The remittance advice indicates the claim line was split into two lines, one E0990NURTKEKX paid and one E0990NULTKEKX was denied as CO-151. Also, the claim line that paid was paid with an incorrect allowed amount. This was for a repair/replacement of elevating leg rests for a patient owned wheelchair that was covered by Medicare. How should we bill for bi-lateral elevating leg rests so that we can receive the correct payment?**

   Answer: Modifier RA is reported on durable medical equipment, prosthetic, orthotic and supplies (DMEPOS) claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged, or when the equipment is replaced because it has been in continuous use by the patient for the equipment's reasonable useful lifetime. Modifier RB should be reported on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

   Options and accessories, such as elevating leg rests, adjustable arm rests, and seating systems, are considered separately covered items, and are not a component part of the base equipment. Therefore, when it is necessary to replace options or accessories that are broken beyond repair, the supplier must submit the claim for the option or accessory as a "replacement" of the original item by appending modifier RA to the claim line (along with all other applicable modifiers). In the example provided for bi-lateral elevating leg rests (E0990) following is the correct manner in which to bill the Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

On the claim line: E0990NUKERA99
NTE segment: E0990NUKERAKXLTRT
NTE segment: Narrative explanation indicating the reason for the replacement

To avoid unnecessary denials, suppliers should include a narrative explanation when submitting the initial claim for a replacement item. Suppliers must provide the required narrative explanation in the NTE segment of the 5010A1 professional electronic claim format. If billing using the CMS-1500 paper claim form, suppliers may report this information in Item 19 of the claim form. In the narrative explanation, include information as to why the patient can no longer use the prior item, or why the item cannot be repaired.

Also, when billing modifiers RA, documentation must be maintained in the beneficiary's file and be available upon request from the DME MAC or the program safeguard contractor (PSC).

In the scenario provided, the claim was incorrectly submitted to Medicare and because the RA modifier was missing the claim was not stopped to review the narrative indicating these were replacement elevating leg rests. It appears the claim was based on the "payment record" on file for the previous elevating leg rests billed to Medicare.

2. When would it be acceptable to dispense, upon physician's order, both a wheelchair and a walker? The "Medicare 201 Advanced Billing Seminar" follow-up question and answer document states the following:

Question: Patient's sometimes require a walker for transfers and to use for ambulating short distances inside the home, does Medicare allow for the payment of both a walker and wheelchair at the same time?

Answer: Medicare may cover more than one type of mobility assistive equipment (MAE) at the same time, if the patient requires the equipment to accomplish a different mobility-related activity of daily living (MRADL). For example, a beneficiary utilizes a manual wheelchair in the kitchen for meal preparation, but needs a walker in the bathroom for.

What would be the supporting documentation? Is there a length of need that is generally accepted for a manual wheelchair base when used in conjunction with a walker (i.e., patient's condition is expected to improve to use the walker instead of the wheelchair).

Answer: The patient must first qualify for the wheelchair even if he/she only needs the walker for minimal use such as getting into the bathroom to pivot/transfer. The documentation should support the general need for the wheelchair as the primary MAE and then describe the needed usage for the walker. For example, if the walker is being used for the bathroom because the wheelchair cannot fit, we would need documentation regarding coverage criteria for the wheelchair being met, room

dimensions, and that the patient is able to pivot and transfer with the walker to get to the toilet. In most cases the beneficiary would not have a need for both items.

Enteral/Parenteral/IV Therapy

3. The local coverage determination (LCD) for External Infusion Pumps (L11555) states the following:

"Drugs and supplies that are dispensed but not used for completely unforeseen circumstances (e.g., emergency admission to hospital, drug toxicity, etc.) are covered. Suppliers are expected to anticipate changing needs for drugs (e.g., planned hospital admissions, drug level testing with possible dosage change, etc.) in their drug and supply preparation and delivery schedule."

Could you please clarify exactly what would be considered "unforeseen circumstances" as well as how, exactly, we would document such a scenario? For example, if we dispense a product on the same day that a patient is admitted to the hospital due to an emergency, it would seem that this would qualify as "unforeseen," as we would not have known of the emergency admission and cannot take product back once released from our care. This very scenario has been denied under appeal. A similar situation would be if we release shipment on what turns out to be the date of death.

Answer: The situations described above seem to be appropriate ones for coverage. If other specific examples of submitted circumstances are of concern, please send those for our consideration. Remember that for the example of the beneficiary who is admitted to a place of service other than the home, such as the hospital, the refill rules still apply and there would need to be an adjustment of the billing calendar going forward to reflect proper exhaustion of supplies before the acquisition of more.

Respiratory Care Equipment/Oxygen Therapy

4. Per the positive airway pressure (PAP) policy, the sleep study must be interpreted by an appropriately credentialed physician. Are there any options other than an advanced beneficiary notice of noncoverage (ABN) if the physician is not credentialed in sleep medicine? For example, can the raw data from the sleep study be provided to a different (credentialed) physician to read, interpret and provide his/her summary?

Answer: As per the PAP policy:
"…..The test must be ordered by the beneficiary's treating physician and conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements."

In addition to meeting this requirement, as long as the data from the Medicare approved sleep study is interpreted by an approved physician according to the PAP policy rules, the study results are then

acceptable for the consideration of coverage of a PAP device under the DME benefit. If these requirements are not met, then a properly executed ABN is appropriate.

5. **We have a case where a patient is on PAP therapy and sees a pulmonologist as part of ongoing follow up. The doctor orders a nocturnal oximetry done by qualified independent lab and then orders oxygen (bled into PAP) when he reviews the results of the nocturnal oximetry. What if the face-to-face/office visit is not within 30 days of the start of the 02 order, due to the whole process?**

   Answer: In order to meet coverage criteria for Oxygen the patient must be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification. The initial date is generally understood to be the date of delivery of the oxygen equipment. In order to meet coverage criteria for both PAP and Oxygen the patient must also meet the requirements as outlined in both policies. The described scenario is not detailed enough to venture a decision of coverage or non-coverage.

Prosthetics/Orthotics

No questions submitted

Rehab Equipment

6. **We have a concern with how the reimbursement for code K0108 is calculated in Jurisdiction B. Attached is a sample explanation of benefits (EOB) as a reference for this issue. On this particular claim, Jurisdiction B only allowed a little over 6% of the billed charge and approximately $124.00 less than their acquisition cost. There is no way a provider can provide necessary items that are coded as K0108 at an 80% loss. What methodology is being used to calculate such low reimbursement rates for K0108?**

   Answer: The Centers for Medicare & Medicaid Services (CMS) is responsible for the accurate and appropriate calculation and implementation of DMEPOS prices. Unusual services and items are generally reported to the DME MAC with miscellaneous Health Care Common Procedure Coding System (HCPCS) codes and are priced using individual consideration based upon information provided by the supplier i.e., item description, manufacturer name, product name and number, and the suggested retail price. Gap-fill pricing may also be used in these situations. If you do not agree with the amount you were paid for the item you should utilize the Medicare appeals process and request a Redetermination.

Ostomy/Urological/Medical Supplies

7. **National Government Services, recently sent out an e-mail update dated May 17, 2012 titled, "Reminder: Frequency Guidelines for Ostomy Supplies" this article states that when billing for quantities greater than the maximum listed in the policy, the supplier must provide a narrative explanation in the note (NTE) segment of the electronic claim or Item 19 of the CMS-1500 paper**

claim. The note should include the acronym UOS, for unit of service, followed by the actual number of units of service submitted. Claims submitted for ostomy supply Health Care Common Procedure Coding System (HCPCS) codes for quantities greater than the usual maximum allowance which do not contain the narrative information as indicated above, will be returned as unprocessable with American National Standards Institute (ANSI code CO-16, Remark code M53, missing/incomplete/invalid days or units of service. Claims returned as unprocessable with CO-16, M53 must be corrected and resubmitted.

a. **If the policy allows 10 units of service for an item, but we provide 15 units of service, we need to indicate in the NTE segment UOS 15. Why does a supplier need to tell Medicare in the NTE segment they are providing 15 units of service when the units of service billed provides that information?**

   Answer: Through data analysis, National Government Services has identified a trend of claim submission errors where the units of service submitted was keyed incorrectly e.g., supplier intended to bill 10 units of service and billed 100 units of service. The requirement to enter the units of service information in the NTE segment was implemented in an effort to reduce these claim submission errors so that suppliers are paid correctly the first time and to prevent improper payments, unnecessary overpayments and claim reopenings.

b. **Does the supplier need to provide anything else in the NTE segment to show why they are billing for quantities greater than the maximum normally allowed or will this narrative explanation in the NTE segment be a red flag to Medicare to review some of these claims?**

   Answer: Suppliers should follow the instructions provided in the article titled, "Reminder: Frequency Guidelines for Ostomy Supplies," additional information is not necessary. Medicare audit contractors (i.e., DME MAC Medical Review, Comprehensive Error Rate Testing (CERT), Medicare Recovery Auditors, etc.) utilize data analysis to determine what items/services should be reviewed to prevent improper payments; determining what to review is not driven by billing instructions provided by the DME MACs.

c. **How should we bill for 15 units of service of a urological item that the doctor orders, when the policy allows for 10 units of service per month and the documentation we have only supports providing 10 per month? Do we bill 10 using a KX and a second line for 5 not using the KX? We would obtain ABN for the 5 that the documentation does not support. How would we handle similar situations with ostomy supplies that do not use KX modifiers?**

   Answer: When the quantity of supplies ordered by the physician is not substantiated by documentation within the beneficiary's medical record, the supplier may execute an ABN to inform the beneficiary of the expected denial. If the beneficiary requests to receive the additional quantities and signs the ABN agreeing to pay for the additional quantities, the supplier should submit the claim as an upgrade utilizing modifiers GK and GA.

Submitting a Claim for the Upgrade Item and Charging the Beneficiary

Suppliers must bill two line items for upgraded DMEPOS items in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item actually provided to the beneficiary with the dollar amount for the upgraded item. If the supplier has a properly executed ABN on file signed by the beneficiary the supplier appends the GA modifier to the HCPCS code. In this situation the claim line submitted with the GA modifier will be denied as not reasonable and necessary with a "patient responsibility" denial.

Line 2: Bill the appropriate HCPCS code for the reasonable and necessary item and append the GK modifier. The claim line submitted with the GK modifier will continue through the claims processing system.

- Line 1: HCPCS A4351KXGA – Submitted amount: $180.00 – Units of service 250
- Line 2: HCPCS A4351KXGK – Submitted amount: $130.00 – Units of service 200

The same information would apply for an ostomy item that does not require a KX modifier.

- Line 1: HCPCS A4381GA – Submitted amount $75.00 – Units of service 15
- Line 2: HCPCS A4381GK – Submitted amount $50.00 – Units of service 10

The KX modifier has a different definition depending on the LCD in question. For example, in the LCD for Urological Supplies the KX modifier is added to a HCPCS code only if the order indicates that the patient has permanent urinary incontinence or urinary retention, and if the item is a catheter, an external urinary collection device, or a supply used with one of these items.

However, if the physician orders a quantity of supplies that exceeds policy limits, but the need for the additional quantity is justified in the beneficiary's medical record, the supplier would submit the claim for the entire quantity of supplies on one claim line (appending all necessary modifiers). If Medicare system edits prevent payment on the claim and the claim is denied, the supplier may request a redetermination, making sure to provide the necessary documentation to support coverage of the excess quantities.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

8. **Refill policy now states: For non-consumable supplies (i.e. positive airway pressure and respiratory assist device supplies) – the supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).**

This appears to be new -- or is this deemed a clarification? We now need to document that they have no remaining supplies AND "the PAP mask is no longer functional as it is leaking more frequently," "the filter is now green," "the headgear is stretched out," "the water chamber is cracked," "the tubing is corroded," etc. The general guidelines are to replace equipment at regular scheduled intervals to prevent infection and promote effective treatment of the condition. Now it appears that the supplies must be non-functional before they can be replaced? The patient can no longer be proactive and replace just before the mask becomes non-functional.

Answer: The CMS Program Integrity Manual (PIM) refill requirements preclude the automatic dispensing (refill) of any supply item. Since the original instructions were published in August 2011 requiring the assessment that the supplies are "nearing exhaustion", we have had numerous questions from the original publication about how to document the "near exhaustion" of supplies and what to do with items that are not used up or consumed such as PAP or Respiratory Assist Device (RAD) supplies. We revised the publication in response to these questions.

We deliberately did not provide specific guidance as to how a supplier might assess the need for replacement of non-consumable supplies, leaving as much flexibility to the supplier's discretion as possible. The PIM 5.2.6 refill requirement requires a determination that the need for the refill is justified. Recognizing that there are differing products and business practices, allowing each supplier to decide how to best assess and document the need for replacement was most the appropriate course.

Regarding the term "functional", there are numerous reasons that would render durable supplies non-functional. Breakage, wear, contamination etc. are some common examples. Replacement assumes reasonable effort to maintain the items per the manufacturer's instructions. With basic care these items remain useable and uncontaminated for extended periods. For example, we all recognize that improper or neglected care can render items dirty and contaminated. However the solution is proper care and cleaning, rather than frequent replacement. When the item becomes unusable for reasons such as damage, wear, soiling or contamination that is unable to be removed with recommended cleaning, etc., the item can be considered to be nonfunctional and may be replaced.

9. **We are associated with a hospital which is doing home tests and would like to know if the hospital system owns sleep lab and the sleep lab provides a Home Sleep Test (HST), can we provide the PAP? We have no financial ties with the sleep lab. The LCD allows this if the test is an attended Polysomnogram, but I am unclear if the same exemption is in place for HST.**

Answer: The policy requirements state that the HST may not be performed by the supplier. If the supplier is not associated with or does not have a financial relationship with the entity performing the HST then they may supply the PAP device. Your example indicates there may exist a financial relationship of your parent company, the hospital, with the sleep center and that may preclude your ability to supply the PAP equipment. Your organization may consider seeking advice of outside counsel for specific application of this to your setting.

10. **We had a Medicare representative come in for our revalidation and he told us all warranty information had to be on 8 ½ by 11 piece of paper. We were surprised at this and could not find this in writing, can you tell us if this is a requirement and where it is in writing? He did not want to see the warranty information we provide from the manufacturer, he said it had to by on 8 ½ by 11 piece of paper.**

    Answer: This is a question that cannot be addressed by the Jurisdiction B DME MAC. You should contact the National Supplier Clearinghouse (NSC) for questions related to enrollment and revalidation. The NSC Web site address is: http://www.palmettogba.com/nsc.

11. **Same day, same assignment. We have always understood that services provided on the same day all had to be assigned or non-assigned, that we could not accept assignment on some items that day and courtesy bill non-assigned for other items on the same day. We spoke with Tamara Hall and she indicated this is not true, that claims are considered on a claim by claim, line by line basis as far as assignment. Can you please clarify?**

    Answer: The non-participating supplier can choose on a claim by claim basis whether or not to accept assignment, except where CMS regulations require mandatory assignment, i.e., Medicare covered drugs, dually eligible beneficiaries. This information can be found in the Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, and Section 30.3.2.

12. **If we have delivered a rental item (oxygen, PAP device, hospital bed, etc.) to a customer prior to their Medicare eligibility, we have a delivery ticket with that original delivery date. If they later become eligible for Medicare, we of course start billing Medicare for that rental (assuming we have qualifying documentation) with the next rental date in the billing cycle.**
    a. **Do we need to pick-up the equipment that was previously delivered prior to Medicare eligibility and provide "new" or refurbished equipment to the patient prior to our initial claim to Medicare?**

    Answer: What was done with a prior payer is not relevant to Medicare coverage. When Medicare provides coverage for equipment, it is as if each episode is new. This means that all applicable payment rules must be met. There is no exception or waiver for equipment already in place from some other source. A supplier would have to provide new or newly refurbished equipment to the beneficiary. Continuing to bill for "other payer" rented oxygen equipment or billing Medicare for equipment already purchased by and owned by the beneficiary is not allowed- this would be considered a false claim.

    b. **If we do not need to pick-up the previously furnished equipment, do we need a delivery ticket signed by the beneficiary that matches the initial date of service billed to Medicare?**

Answer: See answer to 12a above.