National Government Services

A CMS Contracted Agent

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Jurisdiction B Council A-Team Questions
Sorted by A-Team
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Respiratory Care Equipment/Oxygen Therapy

1. **Now that it has been clarified that PAP supplies are considered non-consumable, are we still able to dispense a three-month quantity? Are PAP filters considered non-consumable?**

   You may still dispense a three month quantity if medically necessary. PAP filters are non-consumable as they are not "used up." However for disposable ones, Medicare allows up to 2 per month and for the non-disposable ones, Medicare allows up to 1 every six months. The reason for replacing these would still have to be noted such as "not clean" or "broken in half" etc. Please refer to question 12 in the article published August 31, 2012, titled "Frequently Asked Questions – Refill Requirements for Non-consumable Supplies."

2. **If a patient qualifies for home oxygen with a qualifying oximetry test on room air and the physician orders oxygen and completes the oxygen Certificate of Medical Necessity (CMN) and indicates in question five that the patient requires greater than 4 liters per minute (LPM); however, the ordering physician does not test the patient on 4 LPM, therefore question six on the oxygen CMN is not answered.**
   a. **What is the correct procedure for billing oxygen when the CMN indicates greater than 4 LPM ordered but patient was not tested at 4 LPM? Patient "qualifies" for oxygen but not for the greater than 4 LPM ordered.**
   b. **Is an Advance Beneficiary Notice of Noncoverage (ABN) required in this situation?**

   If question five indicates the flow rate ordered for the patient is greater than four LPM and question six is not answered or does not support the medical need for greater than four LPM, the QF or QG modifiers should not be appended. The claim will pay or deny accordingly.

   This direction was previously provided in a listserv message titled, "Reminder: Revised High Liter Flow Oxygen and Oxygen Equipment Payment and Billing Guidelines." This article was initially sent

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out in August 2011 and is also posted on the National Government Services Web site under Policy Education.

An ABN would not be necessary unless you have reason to expect that Medicare is likely to deny the oxygen as not medically necessary.

3. **Oxygen Pre-payment Audit:**
   a. **Is there any timeline for how long all claims will be subjected to pre-payment audit?**
      At this time CMS has not provided a timeframe or end date for these audits.
   b. **Is there any data regarding initial denial rate vs. claims paid on redetermination, reconsideration or ALJ appeal?**
      Currently, there is no data available regarding denial rates versus claims paid upon reconsideration or ALJ. However, once the data is available, the information will be shared with suppliers.
   c. **Any thoughts for streamlining/improving the process to reduce paperwork and resource burden on the providers and CMS? If a claim does not pass the initial review, could a denial reason be provided instead of just "CO-50"?**
      Suppliers may utilize esMD to submit their documentation based on an additional documentation request (ADR) letter received. This opportunity will reduce paperwork. These audits are completed on a front-end basis and are widespread at this time as per directions from CMS. A results letter is not provided as is done with a medical review audit. The only denial suppliers will receive at this time is the CO-50 on the explanation of benefits (EOB).

4. **When a Medicare beneficiary receives a replacement CPAP after the five year RUL, the PAP Coverage and Documentation states a new face-to-face examination and new order is required. What is the time frame for this face-to-face exam in relation to the beneficiary receiving a replacement CPAP? Beneficiary is receiving routine/yearly follow–up visits with use/benefit/compliance documented. If someone's CPAP all of a sudden doesn't work and they bring it in one day to have it checked and it cannot be fixed, the beneficiary is going to need it right away but they may not have had a face-to-face immediately prior to the machine failure.**

   If the equipment is being replaced due to RUL then there must be a face-to-face evaluation by the beneficiary's treating physician that documents the beneficiary continues to use and benefit from the PAP device. The face-to-face evaluation should occur "timely."

5. **In reference to high liter flow oxygen patients (greater than 4 LPM), can a patient be tested on oxygen at greater than 4 LPM and qualify for the higher reimbursement based on the CMN question set? Example: patient is tested on 5 LPM and the patient's saturation was 87% and the physician then prescribes 6 LPM. Is this acceptable or does the patient need to be tested on 4 LPM?**

   The LCD for Oxygen and Oxygen Equipment states the following: "If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a **blood gas study performed while the beneficiary is on 4 or more**

LPM meets Group I or II criteria. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. (Refer to related Policy Article for additional information on payment for greater than 4 LPM oxygen.)" Therefore, the answer is no, the patient does not need to be tested on 4 LPM to qualify for the higher liter flow. The scenario provided would be acceptable.

Assuming that a test performed at 5 LPM is acceptable, how should the physician properly complete question 6 of the CMN since the instruction is: "Enter the results of the most recent test taken on 4 LPM."

The physician should enter the test results from the test performed while the patient was on 5 LPM.

Rehab Equipment

6. **Occasionally, we will provide a power wheelchair to someone who at the date of service is not eligible for Medicare, but the customer may then become eligible for Medicare with a retroactive eligibility date (example, someone receiving Medicare due to a disability or illness such as ALS). Once the customer gains that eligibility, the original insurer may ask for a refund and expect Medicare to be billed as the primary payer. If a customer in this scenario, who lives in one of the 7 demonstration states, had received a PMD included in the prior authorization project….how would that claim be processed? The provider would have been completely unable to obtain prior authorization before the delivery, as the customer was not eligible at the time. The assumption is the claim would go through pre-payment review; but would the 25% payment penalty be applied if the claim was approved? If so, this seems very unfair for a provider who did not have the prior authorization option. If the provider submits evidence of the retroactive eligibility would the DME MACs process and pay the claim without applying the financial penalty?**

   If the supplier submits a claim without first submitting a PAR and receiving an affirmative response from Medicare, the claim would be subject to the pre-payment review. If all of the documentation and medical necessity requirements are met the payment would be subject to the 25% payment penalty. The payment reduction is not appealable; therefore the supplier would not be able to submit evidence of a retroactive eligibility date in order to avoid the 25%. If the supplier does have the required documentation and the beneficiary meets coverage criteria, the supplier should submit the PAR before submitting the claim in order to avoid the 25% reduction – even if the PMD has already been delivered. The supplier should only submit the documentation that is required for the PAR:

   1. PMD PAR Coversheet
   2. Face-to-face documentation
   3. 7-element order
   4. Detailed Product Description
   5. Any other necessary clinical information

If the supplier determines the beneficiary did not meet the coverage criteria or the supplier does not have the documentation required by Medicare, the supplier may either submit the claim for a denial or start the entire rental/purchase process over again.

Documentation/Regulatory/Miscellaneous/Other

7. **Medicare Learning Network (MLN) Matters article SE1227 regarding Medicare secondary payer clearly states that participating providers are not allowed to collect any co-payment, co-insurance, or deductible when services are rendered, if Medicare is secondary to another insurer. What are the rules for non-participating providers? Any distinction for non-assigned claims?**

   MLN SE1227 states the following: "Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed Care Organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment." Therefore, if the supplier is non-participating and billing a non-assigned claim, they may collect the entire submitted charge up front from the patient, unless the item provided falls within the mandatory assignment provisions (i.e., certain drugs).

8. **Does Medicare consider a video conference (Skype) between the patient and the treating physician, acceptable evidence of a face-to-face evaluation as long as the interaction is documented in the patient's medical record?**

   If all CMS requirements for a valid telehealth face-to-face visit are met, a video-conference does meet criteria. The mode of telecommunications is not an issue. It may be via telephonic lines, satellite, T-1 lines, etc. The requirements are that the Medicare telehealth criteria for E&M services are fulfilled. Additional information regarding telehealth requirements may be found in the Medicare Learning Networks Matters, Telehealth Services, *Rural Health Fact Sheet Series*, published in February 2012.

9. **The supplier manual indicates a supplier must sign a verbal order. In most cases we document a verbal order in our computer system but that documentation is not printed and signed. I have reviewed the PIM and do not find the requirement for a supplier to sign a verbal order. We understand the requirement for the physician to sign a written dispensing order but where can we find this requirement from CMS and what is the expectation for documentation of a verbal order that is captured electronically by the supplier.**

   This requirement is part of the Standard Documentation Language for Local Coverage Determinations that became effective March 12, 2012, and can also be found in the Jurisdiction B Supplier Manual,

Chapter 8. If the supplier signature is an electronic signature then all applicable electronic signature rules apply.

10. **Please explain when a new delivery ticket is needed. In the past, when a patient became Medicare eligible after they already had equipment (i.e., oxygen), you needed to get a new initial qualifying CMN and verify the patient saw the treating physician no more than 30-days prior to that initial date. We are now being told we need a new delivery ticket. Please explain the reason for this. The responsibility of the supplier to provide their warranty on the equipment does not change, they still have to offer the warranty effective from the first bill date, and the transfer of ownership that happens after the 13-month rental (capped rental) still happens. Why are we now being told there has to be a new delivery ticket when there does not have to be a new delivery of equipment?**

    New or newly refurbished equipment must be provided to the beneficiary in order to receive a payment from Medicare. This is not a new rule. This has always been a requirement – see the Internet-Only Manual, 100-08 *Program Integrity Manual*, Chapter 5, section 5.3.1. Once a beneficiary becomes Medicare eligible and is seeking payment for a DMEPOS item, even if the item was obtained prior to Medicare eligibility, all Medicare Fee-for-Service (FFS) payment and documentation rules apply to a beneficiary at the time of their initial enrollment, regardless of their prior insurer. Current proof of delivery is required. For items that require a Certificate of Medical Necessity (CMN), the "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the "Initial Date" of the CMN or DIF or 3 months from the date of the physician's signature. There are no rules regarding a warranty – that is not the issue.