Jurisdiction B, C and D Combined Council Questions

Sorted by A-Team
May, 2015

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Enteral/Parenteral/IV Therapy

No questions submitted.

Education

No questions submitted.

Home Medical Equipment

No questions submitted.

Oxygen

1. **Since Medicare accepts other idiopathic diagnosis, such as idiopathic pulmonary fibrosis or idiopathic pulmonary hypertension, why doesn't Medicare accept an idiopathic hypoxia diagnosis? Why is there a disparity between acceptance of hypoxia as a diagnosis?**

   Response: The Oxygen and Oxygen Equipment Local Coverage Determination (LCD) is not a diagnosis driven policy. Moreover, hypoxia is not a diagnosis; it is a sign and is non-specific. Medicare policy requires that in order to qualify for home oxygen therapy, the beneficiary must have a "severe, chronic underlying lung condition" and be in the "chronic stable state." Idiopathic hypoxia is non-specific as to the cause of the hypoxia and thus does not allow for a coverage determination.

2. **Patient has been on oxygen for five years. One of their diagnoses is Obstructive Sleep Apnea (OSA). However, they did not have a Polysomnogram (PSG) and Medicare paid their 36 months of rental based on an overnight sleep test. Now they need new equipment and a new five year Reasonable Useful Lifetime (RUL). However, under today's guidelines, the original test really does not qualify them. Do they need to have a titration PSG to get their new equipment?**

   Response: Repeat blood gas testing is not required for replacement oxygen equipment; the most recent qualifying test must be reported on the Certificate of Medical Necessity (CMN). If you do not have qualifying test information to report on the CMN then you must follow the rules

outlined in the Oxygen Local Coverage Determination (LCD) to qualify the patient for home oxygen. The answers for requalifying are found in an article published in January, 2009 entitled: "Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Contents (CMS Message 2009-01-28)".

Positive Airway Pressure (PAP)/Other Respiratory Care Equipment

3. **The policy for qualifying a patient with an OSA diagnosis states the following:**

    a. **The titration is conducted over a minimum of two (2) hours; and**
    b. **During titration:**
        i. **The AHI/RDI is reduced to less than or equal to an average of ten (10) events per hour; or**
        ii. **If the initial AHI/RDI was less than an average of ten (10) events per hour, the titration demonstrates further reduction in the AHI/RDI; and**
    c. **Nocturnal oximetry conducted for the purpose for oxygen reimbursement qualification may only be performed after optimal PAP settings have been determined and the beneficiary is using the PAP device at those settings; and,**
    1. **The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation ≤ 88% for 5 minutes total (which need not be continuous).**

We have a patient with a diagnosis of OSA, the patients initial Apnea Hypopnea Index (AHI) was 123 and hypoxic. The patient has had two titration studies and the AHI showed significant improvement to AHI of 18 but the patient was still hypoxic. Since the lab could not get the patient's AHI under ten, but the patient was still hypoxic, is there any way to qualify this patient for nocturnal oxygen?

Response: In order to meet criteria for chronic oxygen therapy coverage in a beneficiary with OSA, there must be a "severe chronic underlying lung condition" in addition to the OSA. There is the requirement that the beneficiary be tested in the "chronic stable state" as well. There is no way to tell from the given information if this patient is maximally treated for his OSA and what other "underlying lung conditions" may be present. In this case, you may properly execute an ABN, providing the reason why Medicare is likely to consider the oxygen is not reasonable and necessary. If this is done, and the claim is submitted and then denied, you would receive a PR denial. The other option is to request individual consideration at the redetermination level, which would require that medical documentation be submitted to show that the beneficiary's OSA is adequately treated, thereby unmasking the clinical effects of the "other" chronic underlying condition. or Medicare coverage, any sleep test must demonstrate the applicable requirements for Medicare. Alternative scoring rules are not applicable for justification of coverage.

4. **With the clarification to the Respiratory Assist Devices (RAD) policy in December 2014, the policy now states Central Sleep Apnea is defined by all of the following:**
    1. **An apnea-hypopnea index (AHI) greater than or equal to five (5); and**
    2. **The sum total of central apneas plus central sleep hypopneas is greater than 50% of the total apneas and hypopneas; and**
    3. **A central apnea-central hypopnea index (CAHI) is greater than or equal to five (5) per hour; and**
    4. **The presence of at least one of the following:**

- **Sleepiness**
- **Difficulty initiating or maintaining sleep, frequent awakenings, or nonrestorative sleep**
- **Awakening short of breath**
- **Snoring**
- **Witnessed apneas**

5. **There is no evidence of daytime or nocturnal hypoventilation**

We are hearing from several labs the software does not have the capability to break out the CAHI. How can we have a CAHI requirement when the software the labs are using does not have the capability to break this out?

Response: Since this definition is based upon polysomnographic scoring recommendations by the American Academy of Sleep Medicine, the requirement stands and the sleep center would have to make arrangements for acquiring this information.

5. **From the July 2014 FAQ from Region B regarding OSA and oxygen we have Q&A #2:**

1. **A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration PSG as described in the oxygen LCD. Following diagnosis and optimal treatment of the OSA during the titration PSG, it is discovered that the beneficiary is not using the PAP device as prescribed (refused the device, is noncompliant, etc.) but the physician has prescribed oxygen for use during sleep. In this instance, would the home oxygen be covered?**

   Answer: Yes, home oxygen is covered. For beneficiaries with OSA, the titration PSG is used to:

   a. **Assure that the OSA is optimally treated thus satisfying the Oxygen LCD "chronic stable state" requirement, and**
   b. **Determine that the remaining hypoxia meets the oxygen LCD qualification threshold.**

   Beneficiary compliance with treatment after testing is not a factor in determining eligibility for payment of home oxygen.

   Note: This answer assumes that OSA is the only other concurrent condition that could affect blood oxygen levels and that the underlying lung disease is adequately treated and stable as required by the oxygen LCD.

Consider these two different situations related to this Q and A:

a. **The beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration polysomnogram (PSG) as described in the oxygen LCD, and uses the PAP device compliantly. If the physician does not prescribe oxygen within 30-days of the PSG, but later orders oxygen what type of qualifying test would be necessary to qualify the patient for nocturnal oxygen? Would the patient need to undergo another PSG titration or would an overnight oximetry test be sufficient?**

b. **A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration PSG as described in the oxygen LCD, but is not using the PAP device compliantly. If the physician does not prescribe within 30-days of the PSG, but later orders oxygen what type of qualifying test would be necessary to qualify the patient for nocturnal oxygen? Would the patient need to undergo another PSG titration or would an overnight oximetry test be sufficient?**

Response: The National Coverage Determination requires that the oxygen testing only be done while the beneficiary is in the chronic stable state. For beneficiaries with OSA this requires that testing be done during a titration PSG as described in the LCDs. Physician documentation of PAP usage is not evidence of chronic stable state (CSS) and is not a factor that determines eligibility for oxygen reimbursement. The CMS Medicare Claims Processing Manual requires that testing must be done within 30 days of the initiation of the oxygen. In the examples above, although a qualifying titration PSG was performed the expiration of the required 30-day testing window requires that new qualifying testing be performed.

Prosthetics/Orthotics

6. **In states that license orthotic fitters, can a licensed 'orthotic fitter' meet the criteria to fit prefabricated custom-fitted orthoses for Medicare beneficiaries?**

Response: Please refer to the joint publication article that discusses this: "Correct Coding – Definitions Used for Off-The-Shelf Versus Custom Fitted Prefabricated Orthotics (Braces) – Revised" which was published March 27, 2014.

7. **In regards to the individual qualified to fit prefabricated orthoses, please define "commensurate education" and "qualified professional."**

Response: It is unclear where the language "commensurate education" and "qualified professional" included in the question is published. For guidance on this, refer to the joint publication article referenced in #6.

Rehab Equipment

8. **How is a file reviewed for a K0835 (in PAR) base, or a base with a sling/solid/seat/back, when the medical reviewer isn't looking at the accessories necessary to pay this specific base? If the request is for a K0835, can it be submitted for Advance Determination of Medicare Coverage (ADMC) as well?**

Response: When a Power Mobility Device Prior Authorization Request (PMD PAR) is submitted, all the coverage criteria for the power wheelchair base are reviewed. In addition, the nurse reviewing the documentation would determine if the following criteria are also met.

1. The beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control).

2. The beneficiary meets coverage criteria for a power tilt or a power recline seating system; and the system is being used on the wheelchair.

The ADMC process is voluntary, and the PMD PAR process is not mandatory; however should the supplier choose not to participate in the PAR program, there will be a 25% reduction in payment that would apply if the power wheelchair is found to be payable. The PMD PAR decision is for the power wheelchair base; however in the event the decision is affirmative and a UTN is provided, when the claim is submitted for the PWC base, then the accessories should be paid. In this setting, the accessories remain subject to future audits for being reasonable and necessary.

9. **An ADMC submission was denied and returned stating that the base must go through the PAR process since it was an eligible code. Is this a CMS requirement for codes that are eligible for both ADMC and PAR? The PAR process does not make a determination on accessories where the ADMC process does. Can a provider submit for both? Jurisdiction C references this in Chapter 9 of the Supplier Manual under ADMC but other Jurisdictions do not.**

   Response: Response provided in Question 8. If you believe an ADMC request was rejected in error, contact the Jurisdiction that rejected the request.

10. **MLN Matters - MM8864 stated that a system-wide fix was to be implemented January 5, 2015 to address the issue of claims paying incorrectly for wheelchair accessories being used with non-competitively bid bases. We have heard that claims are still paying at the incorrect rate after the date of the fix, and a provider in Jurisdiction D was told that the fix was delayed and would not be implemented until later in the year. Has the fix been implemented? Are Jurisdictions correcting past improperly paid claims? If a provider has a claim paid improperly, what is the recourse or procedure for that provider to follow?**

    Response: The DME MACs verified that the system corrections outlined in MM8864 have been implemented and based upon examples reviewed are working correctly. The DME MACs have reopened claims that were incorrectly paid and or denied in error prior to the implementation of MM8864. If you have additional claims that you believe were not adjudicated correctly, contact the Jurisdiction that processed the claim to have the issue resolved.

Ostomy/Urological/Medical Supplies

11. **We have a physician who has sent us the following request: "I'm thinking he would do well with a 10-15mmHg first layer then 20-30mmHg layer over this for a combined 30-40mmHg.**

    There is a paragraph in the surgical dressing article that states:
    For the compression stocking codes A6531 and A6532, one unit of service is generally for one stocking. However, if a manufacturer has a product consisting of two components which are designed to be worn simultaneously on the same leg, the two

components must be billed as one claim line with one unit of service – e.g., a product which consists of an unzippered liner and a zippered stocking.

a. **Is the above stating that we can dispense a 7-15mmHg or compression liner with a 20-30mmHg compression stocking and bill them as a combined compression of 30-40mmHg A6531?**

Response: No, the code for A6531 (gradient compression stocking, below knee, 30-40 mmHg, each) and for A6532 (gradient compression stocking, below knee, 40-50 mmHg, each) are for the pressures described only within the code. Adding the pressures for two stockings together and then billing as that code would be considered a misrepresentation of the policy and is incorrect coding.

b. **This isn't really designed by the manufacturer as "kit" type item consisting of two components that are meant to be worn together but they can be worn together for a customer who may have problems donning a 30-40 mmHg compression stocking versus a 20-30 mmHg stocking. If they are billable, would the doctor need to specifically order them separately with medical notes to justify including something like that they are meant to be worn together for a 30-40 mmHg compression along with justification that patient is unable to apply a 30-40 mmHg stocking and the separate components would increase compliance with wear and medically benefit the patient?**

Response: See the response provided in a.

Diabetic Monitoring and Supplies

No questions submitted.

Documentation/Regulatory/Miscellaneous/Other

12. **With the October implementation of ICD-10, is there any information/guidance/direction on the transition of claims for current rentals? Will there be a period of dual coding or will DME providers need to recode all current rentals before the rental anniversary date in October? This could be difficult if providers have large volumes/multiple capped rental service lines.**

Response: The DME MACs are still waiting for additional instructions from CMS in regards to the implementation of ICD-10. DMEPOS suppliers should continue to watch for E-mail updates from CMS, DME MACs and CEDI regarding ICD-10 implementation.

13. **For patients/ beneficiaries already on a DME suppliers service is a new DWO, DIF, and/ or other medical documentation required with the ICD10 transition that is scheduled to take place on October 1, 2015?**

Response: The DME MACs are still waiting for additional instructions from CMS in regards to the implementation of ICD-10. DMEPOS suppliers should continue to watch for E-mail updates from CMS, DME MACs and CEDI regarding ICD-10 implementation.

14. **Can the DME supplier update its records (DIF) by cross-walking the ICD-9 on file to the ICD-10 based on the medical records they have, or do they need ICD-10 specific written medical documentation from the physician?**

    Response: The DME MACs are still waiting for additional instructions from CMS in regards to the implementation of ICD-10. DMEPOS suppliers should continue to watch for E-mail updates from CMS, DME MACs and CEDI regarding ICD-10 implementation.

15. **If a patient's claim is selected for medical review and denies, subsequent claims will also deny. If the original claim is then paid in Redetermination, can the subsequent claims be reopened? They have a remark code of M25 so we would want to be sure we can reopen and we don't have to send them through Redetermination.**

    Response: Each claim submitted to Medicare has its own set of appeal rights. Therefore, in most cases a favorable redetermination does not necessarily mean that all other claims should be paid. There are exceptions - for instance, for a capped rental item, once medical necessity is established for the item then subsequent claims should be paid if being scrutinized for this reason. However, for items like supplies where specific documentation is required for each date of service (i.e., request for refill documentation, proof of delivery) then the payment of one date of service would not allow for the payment of another date of service.

16. **The LCD for Group 2 support surfaces no longer mentions the 'statement of ordering physician'. There is still a sample form for this statement.**

    a. **Is the form (or a similar format) still requested? Versus a standard WOPD (DWO)?**
    b. **Is the pricing information – supplier's charge and fee schedule allowable, as shown on the sample form – still required to be included on the physician order?**

    Response: The LCD for Pressure Reducing Support Surfaces – Group 2 was revised in March 2013 and removed the requirement for the Statement of Certifying Physician – Effective April 1, 2013. The LCD also states that a detailed written order prior to delivery (WOPD) is required for support surfaces. You must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

    An order (i.e., detailed written order or written or prior to delivery) does not require fee schedule or pricing information). A DWO or WOPD requires the following elements:

    - Beneficiary's name
    - Prescribing Physician's name
    - Date of the order and the start date of the order, if the start date is different from the date of the order

- Detailed description of the item(s)
- Physician's signature and date
- Prescribing practitioner's NPI, if item is subject to Section 6407 of the Affordable Care Act

17. **MM9062 was published on 02/13/2015, effective 07/01/2015. This article discusses allowing providers to transfer title to capped rental equipment to beneficiaries even when 13 months claims have not been paid.**

    a. **Can any provider transfer title any time, or for any reason? Or is the intent of this article to address situations where a provider is exiting a line of business, or closing their doors completely?**

    Response: The intent of this article was not to allow providers to transfer title to equipment at any time but rather to allow for repairs of beneficiary owned equipment when a supplier closes their doors, abandons the beneficiary; or when rare individual extenuating circumstances arise (i.e., even if 13 monthly rentals have not been paid). These instructions do not relieve a supplier who provided the equipment of their obligation to provide equipment that is expected to last through the end of the established RUL with reasonable repairs.

    b. **The article states that at least one claim must have been approved and paid. Would transfer of title allow repair claims to be paid, if one or more claims had been approved, but other claims were denied and are in the appeals process (which may take years)?**

    Response: Medicare does not allow for repairs of equipment which is determined to be not reasonable and necessary. If at any point Medicare has determined that the item being repaired is not reasonable and necessary then repairs would not be considered reasonable and necessary.

CEDI

No questions submitted.

PDAC

No questions submitted.