Jurisdiction B Council A-Team Questions
Sorted by A-Team
May 7, 2009

Home Medical Equipment

1. Our manual wheelchair KE modifier accessories are not paying at the 5% increased rate. Staff is being told that because national competitive bidding was suspended that KE modifiers were also suspended. Claims are denying CO-16 and we're being told to call reopening. Please advise.

   ANSWER: January 1, 2009, the KE modifier was effective and is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. All fee schedules for PMD accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5% reduction for 2009. Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). National Government Services, Inc. is currently processing claims with the KE modifier to allow the 5% increase in fee schedule allowance. The Redetermination Unit has seen an increase in claims not paid appropriately due to the KE modifier being omitted. Specific examples are required to research this issue.

Enteral/Parenteral/IV Therapy

2. Regarding PEN pumps, do we or do we not give purchase option for these pumps? Clarify that the 2008 manual chapter 15 clearly states that PEN suppliers must notify the beneficiary option purchase with the initial claim. Is that information incorrect?

   ANSWER: Yes, the supplier is required to notify the beneficiary of the option to purchase the PEN pump with the initial claim. This requirement is based upon the instruction in the CMS Internet-Only Manual 100-04, Claims Processing Manual, Chapter 20, 30.7.1 which states, "The patient has the option of purchasing or renting the pump from the supplier. Contractors must request written authorization from the patient before or after paying for a pump purchase." The beneficiary may opt to purchase the PEN pump during the initial transaction or at any time during the rental period of the pump. However, there is no requirement that the supplier re-issue a purchase option letter during the 10th month.

3. Recent guidance published by the DME MACs states: Effective for claims submitted on or after April 1, 2009, for supplies and accessories to be used with beneficiary-

owned equipment, all of the following information must be submitted in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims HCPCS code of the base equipment; and a notation that this equipment is beneficiary-owned; and, the date the patient obtained the equipment. Is this information required for drugs and supply kits (A4221 and A4222) used with a patient owned external infusion pump?

ANSWER: This guidance applies to situations in which the Medicare beneficiary:

- **obtained the base equipment prior to joining the Medicare FFS**
- **purchased the equipment him/herself while enrolled in Medicare FFS**
- **had the base equipment paid for by another payer while enrolled in Medicare FFS**

This guidance did not exempt any DMEPOS item; it simply stated that the information above must be included for supplies and or accessories used with patient owned equipment. Therefore, at this time this guidance does apply to all supplies and accessories used with patient owned durable medical equipment. Exp. External Infusion pumps, PAP devices, nebulizers, etc.

4. We have patients that own an infusion pump (E0781) and before they start chemotherapy again they would like to have the infusion pump calibrated and repaired if necessary. Can we bill Medicare for calibration/repair of pump? If we can bill for calibrating pump, would it be under E1340 and after 4/1/09 K0739?

   ANSWER: If a patient owned pump requires repairs, the supplier will need to verify that either the pump was paid for by Medicare or the pump meets Medicare coverage criteria. Repairs and labor that is associated with the repairs can be submitted to Medicare for reimbursement.

   The Center for Medicare & Medicaid Services (CMS) advises that routine periodic services, such as testing, cleaning, regulating, and checking of the beneficiary's equipment is not covered. If a beneficiary requests these services to be done by a third party, they are noncovered, which means the services can be charged to the beneficiary. More extensive maintenance which, based on the manufacturer's recommendations is to be performed by an authorized technician, is covered as repairs for medically necessary equipment.

Respiratory Care Equipment/Oxygen Therapy

5. We have a customer that, after they capped in January 2009, went from a 2 lpm concentrator to 5 lpm liquid. The expense to us is huge. The added expense for this one customer's care has gone from normal and expected to a major monthly unexpected expense. This situation is not that uncommon. Realistically, what is a provider to do to account for these ADDED unforeseen expenses they have to deal with?

ANSWER: Under the new payment policy for oxygen, after the 36-month cap has been met, payment for oxygen contents is available only if the patient was on a gaseous or liquid oxygen system during the 36th rental month. There are no exceptions.

6. What educational resources are available to the referral sources (i.e. hospitals and physicians) regarding the changes to the payment policy for oxygen and oxygen equipment?

   ANSWER: The Centers for Medicare & Medicaid Services' (CMS) National Medicare Education Program (NMEP) enlist national and local organizations to support and participate in the NMEP. To date, more than 200 national and local organizations that work on behalf of the aged and disabled Americans are involved in this public-private partnership. Together with CMS, these national partners are reaching out to other organizations at the state and local levels. They, in turn, are working with Medicare beneficiaries and other interested organizations and individuals to help them better understand the changes to the Medicare program.

   In addition to the NMEP, CMS has held national training teleconferences in an effort to educate the Medicare beneficiaries and the referral sources.

   For more information regarding the changes to the Medicare Payment Policy for Oxygen and Oxygen Equipment, please refer to the following resources:

National Government Services	Jurisdiction B DME MAC Supplier Manual, Chapter 15 *DMEPOS Payment Categories*	March 20, 2009
National Government Services	Oxygen and Oxygen Equipment Question and Answer Documents	February 20, 2009
National Government Services	Oxygen – Certificates of Medical Necessity – Replacement Equipment	February 18, 2009
Medicare Learning Network	Medicare Learning Network Matters Article 6296 - Payment for Repair, Maintenance and Servicing of Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008	February 13, 2009
National Government Services	Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents	February 2, 2009
Medicare	Medicare Learning Network Matters Article 6297 - Changes In	December 23, 2008

Learning Network	Payment For Oxygen Equipment As A Result Of The Medicare Improvements For Patients And Providers Act (MIPPA) Of 2008 And Additional Instructions Regarding Payment For DMEPOS	
Centers for Medicare and Medicaid Services	CMS Publication No. 11405 -Oxygen Fact Sheet for Medicare Beneficiaries	December 17, 2008
Medicare Learning Network	Special Edition Article SE0840 - Changes In Medicare Payment For Oxygen And Oxygen Equipment	November 17, 2008
CMS Medicare Improvements for Patients and Providers Act of 2008 ~ Fact Sheet	Implementation Of Payment Related Provisions In Medicare Improvements For Patients And Providers Act Of 2008	October 30, 2008
CMS Press Release	Payment Provisions In The Original Medicare Program Immediately Affected By The Deficit Reduction Act	February 10, 2006

7. When a patient is discharged from the hospital and has a few months left on their oxygen payments, which DME supplier is responsible?

   ANSWER: When a patient who was on oxygen prior to admission is discharged from the hospital, if the 36-month cap has not been met, payment continues where it left off. The supplier who was providing oxygen prior to admission is required to continue servicing the beneficiary unless the beneficiary elects to switch to a different supplier and finds a supplier who is willing to provide oxygen considering the months remaining in the 36-month payment period.

8. The PAP policy requires the KX modifier. The KX modifier definition in the PIM is that the supplier has the papers in hand. Yet the policy states that the supplier is not REQUIRED to get the paperwork upfront. This seems to be a contradiction. Additionally, the PAP policy had some drastic changes published in January. It seems that the face to face visit for the initial pap eval no longer requires that each specific component (sleep history, sleepiness scale, BMI, neck circumference, cardiopulmonary and upper airway evaluation) be documented. Is this an accurate interpretation?

   ANSWER: Use of the KX modifier on DME claims is not addressed in the PIM. Requirements for the use of the KX modifier vary from policy to policy and are specified in the Documentation Requirements section of each Local Coverage Determination (LCD). The Documentation Requirements section of the PAP LCD defines two separate uses for the KX modifier: first 3 months and beyond 3 months. For the first 3 months' claims, there is no stated requirement for the supplier to

have a copy of the physician evaluation or sleep study report in their files prior to submission of a claim with a KX. However, the supplier would be expected to use other means to determine whether the coverage criteria were met. For claims beyond 3 months, the LCD does state that the supplier must "obtain information from the physician that the beneficiary has demonstrated improvement in their OSA symptoms, and is adhering to PAP therapy". That does not necessarily mean that the supplier must have a copy of the re-evaluation note and compliance report in their files. However, there must be written documentation of some communication with the physician prior to use of the KX modifier. Suppliers must provide all the documentation from the patient's medical record, if requested.

The changes to the requirements for the initial face-to-face evaluation was made in the September 2008 LCD revision. As stated in the Documentation Requirements section, "each element would not have to be addressed in every evaluation."

9. I have two questions and they all revolve around the new PAP policy:
   a. Patient has a private insurance and begins a rental of a PAP device. Eight months into the rental the patient enrolls in the Medicare Fee for Service program. What now has to happen to qualify this patient under the Medicare program? What are the compliance documentation requirements?
   b. If the doctor's office gives us a copy of their protocol stating that a face to face evaluation is completed prior to the sleep study, is that sufficient documentation for the supplier that a face to face is being done so long as the doctor has the actual evaluation in their records?

   ANSWER: a. **The requirements for patients who are using a PAP device when they enroll in Medicare FFS are specifically addressed in the LCD, Indications and Limitations of Coverage section, Beneficiaries Entering Medicare subsection.**

   b. The supplier is not required to have a copy of the evaluation in their records prior to claim submission. However, before a KX modifier is added to a claim, there should be confirmation that the evaluation visit occurred and that it was prior to the sleep study. In the case of an audit, the supplier would be required to provide a copy of the patient's medical record that documents the evaluation.

10. Please clarify what Medicare considers the useful life of equipment. Is it 5 years from initial setup (i.e. customer started rental through another carrier prior to Medicare coverage - including MRP's) or 5 years through Medicare only.

    ANSWER: The reasonable useful lifetime (RUL) calculation of the equipment does not take into consideration coverage under other insurance prior to the patient's enrollment in the traditional Medicare fee-for-service (FFS) plan (including a

Medicare Replacement Plan). The five year RUL calculation begins with the beneficiary's enrollment in the traditional Medicare FFS plan.

11. If a patient switches from regular liter flow (1- 4 lpm) to high-flow (above 4 lpm), does a new 36-month cap rental start when the patient changes to high-flow?

    ANSWER: No. A new 36-month rental period does not begin in this situation. However, during the 36-month rental period there will continue to be payment adjustments for beneficiaries receiving more the 4 LPM or less than 1 LPM, as is the current policy. This applies only to patients with a stationary gaseous (E0424), stationary liquid (E0439), or stationary concentrator (E1390, E1391).

    A new 36-month rental period can start in the following situations:
    - **Reasonable useful lifetime of the equipment has been reached**
    - **Loss, theft, or irreparable damage**
    - **Break in medical need of 60 days, plus the days remaining in the last paid rental month (during 36-month rental period only)**

12. The Jurisdiction B listserv dated 1/27/09 states *"you must also have proof of delivery documentation in your files for the item being replaced that documents that the oxygen equipment has been in use for at least 5 years."* In many situations, a patient switches companies and the previous supplier is unable or unwilling to provide the original delivery ticket that shows the patient has been on oxygen equipment for five years. Medicare has this information in the form of the Initial CMN date and the number of months billed and paid. Isn't this information sufficient enough to show that the equipment has been in use for five years?

    ANSWER: Current instructions from the Centers for Medicare & Medicaid Services state that the supplier must have proof of delivery documentation on file for the item being replaced; however, Medicare contractors are aware that there are situations in which a supplier may not have access to proof of delivery documentation, such as when the supplier that delivered the original equipment has gone out of business or does not/will not provide the requested proof of delivery documentation. Therefore, we are seeking CMS guidance regarding how to handle documentation requirements for replacement of oxygen when a supplier is unable to obtain the required proof of delivery.

13. For patients beginning a new five year cap, the Jurisdiction B listserv dated 1/27/09 states no new testing is required – but then states *"New testing, however, is not required unless it is necessary in order to meet existing medical review guidelines for oxygen and oxygen equipment."* Please give examples of when new testing would be required according to this statement.

ANSWER: A new certificate of medical necessity (CMN) is required; however, new testing is not required. The test date to be entered on the CMN is the most recent qualifying test. That may be the original test for group 1 patients or the retest (on 61st to 90th day) for group 2 patients. However, if a test has been done since then and if the results of that test are in the qualifying range, that is the test that should be reported on the CMN.

14. We have a patient that has had an oxygen concentrator (E1390) for over 60 months (set up in 1999) and the patient went into a nursing home for one year in 2007. Not all 36 months of payments have been made. Once all 36 months have been incurred, what date can we give the patient the choice for new equipment and start the 36 month cap?

    ANSWER: The reasonable useful lifetime (RUL) for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the beneficiary and continues until the point at which the stationary or portable oxygen equipment has been used by the beneficiary on a continuous basis for 5 years. Computation of the RUL is not based on the age of the equipment. There will be instances in which the RUL will be met prior to the 36-month cap. In the scenario provided above, because the patient was initially set up on oxygen in 1999, the RUL for the oxygen equipment is considered met as of 2004. In this case, the beneficiary may elect to receive new equipment and start a new 36 month cap.

    For additional details regarding the billing of replacement oxygen equipment, please refer to article titled *Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents*. To access this article, please visit the National Government Services Web site at www.NGSMedicare.com, click on the News and Publications menu and select the What's New link.

15. We have a patient that has an oxygen concentrator (E1390) and portable system (E0431). If they want a portable oxygen concentrator (E1392) or a second concentrator for their convenience can we charge the patient for the portable concentrator/second concentrator by obtaining an ABN that this is duplicate equipment? How does this situation apply when the patient is in month 1 to 36 and is it different when they are in month 37 to 60?

    ANSWER: Under the new payment provisions for oxygen and oxygen equipment, suppliers are reimbursed monthly for furnishing medically necessary oxygen equipment and contents to the Medicare beneficiary. In addition Medicare quality standards for respiratory equipment, supplies, and services established in accordance with 1834(a)(20) of the Social Security Act, required the supplier to provide services 24 hours a day, 7 days a week as needed by the beneficiary. Therefore, there should not be a need for the patient to have back up or secondary

equipment. Under no circumstance may the supplier bill beneficiaries separately for these services. In the scenario provided above, the supplier may swap out the stationary concentrator for the portable concentrator at any time during the 60 month benefit period if it is deemed that the portable concentrator will be more appropriate for the beneficiary's use.

16. We have a patient who received a CPAP (E0601) on December 5, 2008 from a different supplier. The patient had a physician visit on October 31, 2008 and sleep study that qualified on November 17, 2008. The patient returned their CPAP on their own to that supplier on January 19, 2009 due to mask issues. The patient saw their doctor on January 2, 2009. The doctor has notes where the patient used the machine 64% of the time when he had the machine and still required CPAP therapy. Therefore, the patient was not compliant and did not show improvement. We have been contacted by the patient to set up the CPAP machine on March 6, 2009. Does this patient need a repeat sleep study and another face to face clinical re-evaluation? Or since the patient did not have the CPAP for a continuous 12-week initial trial, can we bill the third month? If we can bill the third month and the patient is still not compliant with usage after the 30 days, will he need a repeat sleep test and start over the 12-week trial?

    ANSWER: In the scenario presented, a repeat clinical re-evaluation and sleep study are not required for coverage of the March 6 claim because that would still be considered part of the 3 month trial. However, as stated in the LCD, patients who fail the initial 3 month trial must have a clinical re-evaluation by a physician and repeat sleep test in a facility-based setting in order to requalify for a PAP device.

17. A patient has had his oxygen equipment replaced after the 5 year useful lifetime has been met. A new initial oxygen CMN has been obtained but the most recent qualifying saturation test, which was on the patient's lifetime recertification, is 89%. Will this new initial CMN be valid for only 3 months and will the patient be required to be retested between the 61st and 90th day following the initial certification?

    ANSWER: When a new Initial Certification is set up for an RUL replacement, the system will look for a Recertification CMN after 12 months (for Group I patients) or 3 months (for Group II patients). However, retesting is not required on those Recertification CMNs. The physician may enter the most recent qualifying blood gas study.

18. When patients call 1-800- Medicare and are given incorrect information who can this be reported to and will someone be responsible for calling the beneficiary to explain the correct information? Example – A Beneficiary received a letter from the supplier explaining the 60 month lifetime usefulness limit and available options. The beneficiary called 1800-Medicare and was told that this rule did not apply to him

because he was grandfathered and owned his equipment. The Representative also stated that the law did not take affect until 1/1/2009!

ANSWER: If a supplier determines that a beneficiary was provided inaccurate information by the 1-800-MEDICARE contact center, the supplier can contact 1-800-MEDICARE and conduct a 3-way call with the beneficiary to clarify the issue. The supplier can also inform the representative that the Medicare beneficiary was provided inaccurate information on a prior call. National Government Services, Inc. is not the contractor for the 1-800-Medicare line, however, we do partner closely with a contractor affiliated with training and quality for the 1-800-Medicare contact center. If a supplier identifies a situation where beneficiaries are being provided the same inaccurate information on an on going basis, National Government Services, Inc. can elevate the issue to our liaison.

19. A lifetime CMN is on file for E1390 and E0431 dated 9/1/2003. On 1/1/09 the patient requested new equipment. The E0431 has not capped as 36 payments are not showing in the Medicare system. The supplier provides the patient with a new E1390 and obtains a new initial CMN for E1390 dated 1/1/2009. Will the initial CMN dated 9/1/2003 remain active so that the E0431 will continue to pay?

    ANSWER: The requirement of having 36 months paid does not apply to patients who initially received the equipment prior to January 1, 2006. Medicare allows for the replacement of oxygen equipment when the 5-year reasonable useful lifetime has been met and the beneficiary elects to obtain new equipment. The clock begins when the equipment is delivered to the patient. In the example provided, the clock would have began on September 1, 2003 for both the portable and concentrator if both items were delivered on the same day. The patient would have been eligible to elect to receive replacement equipment on or after January 1, 2009, for both the E1390 and E0431. However, if the patient elected to only receive a replacement of the concentrator (E1390) the CMN for the portable (E0431) would remain on file and active to allow continued payment. As a reminder, if the patient does not elect to receive new portable equipment, Medicare will allow for payments up to the 36 rental payments, however, portable contents would not be paid following the 36-month cap if rental payments are being paid on the replacement concentrator.

20. Is NGS aware that overpayments are being made for rental of oxygen equipment when the beneficiary has rented more than one type of modality, I.e., E1390 and E0439? When will a fix be done and will retractions be initiated by Medicare or should the supplier offer a voluntary refund?

    ANSWER: Yes, National Government Services is aware of this issue. This is an issue across the Jurisdictions that CMS is aware of. CMS is working with VIPS and the other DME MACs to resolve this issue and overpayments will be requested.

However, at this time we have not received a timeframe as to when this issue will be resolved.

21. How often can you replace a heated humidifier (E0562) using the RA modifier, whether for broken beyond repair or due to patient upgrade from CPAP to BiPAP (due to medical necessity) where the humidifier is not compatible between the different units?

    ANSWER: There is no minimum time period for replacement of a DME item when it is irreparably damaged due to a specific incident (i.e., not wear and tear) or for provision of a different item due to a change in the patient's condition.

Prosthetics/Orthotics

No Questions Submitted

Rehab Equipment

22. Is the RA modifier required when replacing patient owned equipment that is over 5 years old (providing all the 'requirements" for replacement are met)? There is no change in medical need.

    ANSWER: Yes, suppliers should append the RA modifier on all durable medical equipment, prosthetics, orthotics 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, prior to the equipments reasonable useful lifetime and for billing replacement claims when the DMEPOS item has met its reasonable useful lifetime. Suppliers are encouraged to enter the abbreviation "RUL" which indicates "reasonable useful lifetime" and the date the beneficiary received the original equipment that is being replaced (MMDDYY).

23. The REPAIR LABOR BILLING AND PAYMENT POLICY identifies the Allowed Units of Service when repairing specifically identified items. We'd appreciate your insight and guidance on the following:
    a. How were the number of units determined for the classified equipment? Were providers consulted during the process?
    b. The policy states "Suppliers may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time." This limitation is troublesome as many higher level PMD models, due to sophisticated electronics and anatomical seating systems, take an inordinate amount of time to dismantle in order to facilitate the repair service. The policy does not allow for an avenue to request additional units, even when necessary. It also appears as though technical diagnostic time was not considered part of the labor time.

i. Could we have more dialogue on these issues as we fear beneficiaries will be negatively impacted as many suppliers will be forced to change to a non-assignable business model?

c. The instruction to bill only the 'allowable' number of units is problematic for several reasons. One, this would misrepresent the actual time involved in performing the repair. This may confuse beneficiaries. Two, other payers – both primary and secondary to Medicare – do not have the same rule, and suppliers MUST bull the actual labor time to be compliant with those contracts. Please explain this restriction; or consider allowing providers to bill for the actual time (units) involved in the repair, even if the claim is cut-back and paid at the limited amount.

ANSWER: a. **The numbers of units were determined based on the DME MACs' data analysis, claim review experience, and information from various outside sources. Recommendations for revision of the allowed units may be submitted to the DME MAC medical directors with supporting documentation.**

b. The reason for the instruction to bill only the allowable units of service is due to the fact that code E1340 represents repair labor for a variety of products. There is no automated way for the system to pay the allowed units of service for a specific repair activity.

c. Medicare establishes billing rules based on program needs. The requirements of other payers cannot always be accommodated.

24. I would like to submit for clarification on Rehab question #17 from the Jan 2009 Q & A: Can the information necessary to complete a specialty evaluation be taken from documentation done prior to the face-to-face exam? **ANSWER: No, the specialty evaluation should follow the face-to-face examination. The face-to-face examination is used to establish whether a power wheelchair is necessary. The specialty evaluation is used to identify the specific type of wheelchair and accessories that are needed.**

a. I would like to have clarification that the specialty evaluation can be performed as part of an LCMP evaluation for mobility assistive equipment, which may be prior to the completion of the F2F process as outlined in the LCD: The LCD states - If the patient was referred before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician's visit shall state concurrence or any disagreement with the LCMP examination. In this situation, the physician must provide the supplier with a copy of both examinations within 45 days after the face-to-face examination with the physician

ANSWER: The statements that are quoted from the PMD policy deal with situations in which a PT or OT participates in the face-to-face examination. If that clinician also performs the specialty evaluation at the time of the face-to-face examination, that is acceptable.

25. In the Q & A from January 2009, a question regarding charging beneficiaries' service fees was addressed. It is understood that we are not allowed to bill for just travel time alone, but is it acceptable to bill for labor only if replacement parts were not supplied? Example – for a customer-owned power wheelchair, a service call may be made where a chair is re-programmed, speed is adjusted, wires reconnected, diagnostic tests performed or any other labor preformed where an actual replacement part is not provided. Under these circumstances is it acceptable to bill for labor only?

    ANSWER: The Centers for Medicare & Medicaid Services (CMS) advises that routine periodic services, such as testing, cleaning, regulating, and checking of the beneficiary's equipment is not covered. However, more extensive maintenance which, based on the manufacturer's recommendations, is to be performed by an authorized technician, is covered as repairs for medically necessary equipment. In this situation it would be acceptable to bill Medicare for labor for those necessary repairs even though an actual replacement part is not needed.

Ostomy/Urological/Medical Supplies

No questions submitted

Diabetic Monitoring and Supplies

No questions submitted

Documentation/Regulatory/Miscellaneous/Other

26. Medicare denial CO-179 "patient has not met the required spend down requirements". What does this mean and why is it CO? What can the provider do to remedy the beneficiary status? Previously this same denial code was defined as "patient has not met waiting requirement" and "provider must continue to provide as long as beneficiary needs it". That is no longer stated so can the provider stop providing the equipment?

    ANSWER: Suppliers will receive the CO-179 denial on claims involving maintenance and servicing. This denial can occur because there are not 15 paid rentals if the initial date was prior to 1/1/06. If a supplier believes that the claim was denied CO-179 in error they should request a redetermination and submit documentation to show 15 rentals were paid. Suppliers might also receive this denial if maintenance and servicing is billed and the initial date is after 1/1/06, because the Deficit Reduction Act changed the capped rental guidelines to allow

for a total of 13 rental payments, and then transfer of ownership to the patient. Therefore, Medicare no longer allows for routine maintenance and servicing and instead allows for necessary repairs when they are required.

27. Please clarify the enhancement to the IVR regarding the ability to check a HCPC for a beneficiary against any HCPC that could cause a same or similar equipment denial. Is it possible to get a copy of the list of codes in each category that would be reflected when checking the IVR? Example: If we check a walker code or oxygen code, what codes can we be confident would be reported back?

    ANSWER: Currently suppliers are to verify same or similar though Option 3 on the IVR. Once the authentication elements have been verified, the IVR will supply the following, if applicable:

    - **Initial certification date**
    - **Recertification date**
    - **Revised date**
    - **Length of need**

    At any time during CMN status playback, the caller can give the next Medicare number if multiple CMN status requests are needed. At the end of CMN status playback, the caller has the option of saying; "change HCPCS" to obtain information on another HCPCS code for the same beneficiary. National Government Services in the future will not publish a product category list. Suppliers are encouraged to review the Local Coverage Determinations or Search DMEPOS Product Classification List at www.dmepdac.com to view a listing of the possible HCPCS in a given category.

28. We have a patient who we verified same or similar through the IVR before providing a wheelchair. On 3/2/2009 we received a 151 denial. The ICN # is 09044828315000. We again checked the IVR and no equipment was listed. A call to Mike at Provider Assistance informed us the patient purchased a K0011 on 6/9/05 and that the CMN was "manually entered into the system" so it would ***not appear*** on the IVR. How can we as providers trust the information we are being given?

    ANSWER: Contact was made with the supplier to discuss the patient in question. After receiving the Health Insurance Claim Number (HICN), the IVR was tested and information was pulled up for the K0011. Suppliers are reminded that currently the IVR CMN option only pulls the HCPCS that was entered. If suppliers have any questions in regards to the information received from the IVR, suppliers are encouraged to speak with a Customer Care representative at 1-866-590-6727 Monday – Fridays 8:30 a.m. – 5:30 p.m. Eastern Time.

29. Medicare has published a series of articles on Individuals Authorized to CMS Computer Services (IACS). Does this apply to HME or not?

    ANSWER: At this time, IACS does not apply to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers.

30. Regarding Detailed Written Orders - Sometimes the doctor writes a physician order for respiratory meds, signs it and then faxes to us. The information on the order meets required information for a DWO. Can the fax date count a signature date?

    ANSWER: No, the signature date must be entered on the order by the physician. Date stamps are not acceptable.

31. Regarding gastrostomy tubes - What documentation is required to supply a gastrostomy tube? Is a separate doctor's order needed for this additional supply if and when provided? The manual isn't clear except to say we can supply one tube every 90 days codes (B4087) or (B4088) and that if the formula is covered then all supplies are covered.

    ANSWER: A detailed written order is required for every item that is separately billed to Medicare.

32. What are the documentation requirements for a patient who receives inhalation drugs prescribed because other inhalation drugs have failed to work? For example, Brovana. Does documentation have to be maintained in the patient's chart?

    ANSWER: As with all DMEPOS items, there must be documentation in the patient's medical record (i.e., office notes, hospital records, etc.) that identifies the diagnosis for which the items are provided. For long-acting beta agonists, a recent article stated that the documentation of a "history of routine use" of a short-acting beta agonist (SABA) would consist of supplier's records which indicated that the beneficiary had used SABA therapy at the frequencies listed in the LCD for a period of at least 3 months. The supplier's records could include delivery slips and documentation of the beneficiary request for refill.

33. ADMC's require product information on cushions and seating, IE manufacturer, brand, model, size, etc. Where should this information be conveyed? Does it need to be part of the prescription, detailed order, or separate documentation?

    ANSWER: The information on wheelchair seating products could be part of the detailed written order. If the detailed written order provides only a generic description of the item, then the supplier should provide the product-specific information in a separate statement.

34. We were never able to add modifiers to E1399, only to K0108. Can we now? What if the E1399 is to repair patient owned equipment? It would be nice to be able to add RB so it tips them off to maybe look at the HA0 record for details.

    ANSWER: National Government Services has verified with processing guidelines that it is acceptable for an E1399, K0108, or other Not Otherwise Classified (NOC) codes to have the RB modifier appended.

35. If HCPCS code description indicates equipment is replacement, (i.e., E0981 Replacement Seat Upholstery), do we need to use the RB modifier?

    ANSWER: The new RB modifier should be used 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). In the example provided, the RB modifier must be appended as the seat upholstery (E0981) is a replacement item.

36. Does the order of modifiers on the claim matter? You can have a whole bunch of them on a wheelchair base and or accessories: NU, RR, KH, BP, KX, KE, RT, LT, RA, RB.

    ANSWER: Yes, the order of modifiers on a claim line matter. In cases where more than one modifier is required on the claim line, the pricing modifier (NU, RR, UE, KE) must be placed first following the HCPCS, and then all subsequent modifiers will follow.

37. There was talk of a CPAP/RAD CMN. Any news on this form?

    ANSWER: CMS is planning to utilize a CMN for positive airway pressure devices used for obstructive sleep apnea. Details of the implementation of that CMN have not yet been released.

38. This was published at the end of February related to billing supplies and accessories for patient owned equipment:

    "Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, should the supply or accessory have additional, separate criteria, they must be met also. In the event of an audit or claim appeal, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation and coding requirements."

This is extremely problematic if a beneficiary comes to a provider who did NOT provide the original base equipment, needing a supply or part/repair. For example, if the bene arrives in a power wheelchair, how can the new provider be certain that the bene met medical necessity per policy – and which policy? The policy in effect at the time of purchase, or current policy? Just to replace a seat belt might mean that the new provider would need proof of a qualifying face-to-face exam, copies of any specialty evaluations, and pages of chart notes. Just confirming when the equipment was purchased, and whether Medicare paid for it, can be a time-consuming process. And Medicare payment is not 'proof' that the bene actually qualified or that the original provider had the appropriate documentation on file. This is simply not practical or cost-effective for minor parts or supplies. Please discuss how providers might be compliant with the intent of this rule without over complicating the process.

ANSWER: CMS' policy is that repairs to DMEPOS items are covered only if the equipment itself meets all coverage criteria and that, if requested, the supplier performing the repair must provide documentation to verify that all criteria were met. If the base equipment was billed to Medicare, the criteria that were in effect at the time that the base equipment was provided are applicable. If the base equipment was not billed to Medicare, the base equipment must meet criteria that are in effect at the time of the repair.