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

1. The list serve "Billing Clarification on Support Surfaces" dated 11/17/10, indicates hospital beds on capped rental will result in a same or similar denial if a Group I support surface, code E0184 or E0186 is provided. List serve suggests referring patient back to bed provider. There are still maintenance and service beds out there. What are providers/beneficiaries options if original provider is out of business?

   ANSWER: When claims are submitted to Medicare, the beneficiary's payment history is scanned to ensure that the item being billed is not same or similar to an item that has previously been billed and according to Medicare records is still in use. This includes claims for hospital bed Healthcare Common Procedure Coding System (HCPCS) codes E0250, E0255, E0260, E0265, E0290, E0292, E0294, E0296, E0303, E0304, E0328, and E0290, with a narrative description indicating a mattress is included and the patient is also renting or owns a medically necessary group I (E0184, E0186, E0187, E0196) or group II support mattress (E0277, E0373).

   The article states that beginning December 6, 2010 the hospital bed with mattress (E0250, E0255, E0260, E0265, E0290, E0292, E0294, E0296, E0303, E0304, E0328, and E0290) will receive an ANSI 151 same/similar denial if the patient also rents or owns a Group I or Group II support mattress. Therefore, if the original supplier who provided the hospital bed is out of business they will not be billing the Medicare program for MS of the hospital bed with mattress and will not receive the ANSI 151 denial. The supplier providing the Group I or Group II support mattress will not be impacted.

2. Our understanding is that if a supplier provides a Medicare beneficiary with a capped rental item (i.e., manual wheelchair, CPAP device, etc.) the equipment provided does not have to be

brand new equipment. However, we would like to know if there are any references that we can provide to the beneficiary regarding the policy for capped rental equipment?

ANSWER: There aren't any references that specifically state "a DMEPOS supplier is <u>not</u> required to provide "brand" new equipment to a Medicare beneficiary at the start of a capped rental period", however, Chapter 15 of the Jurisdiction B Supplier manual indicates the following:

- **Repairs of rented equipment are not covered.**
- **Suppliers are required to provide any maintenance and servicing and repairs of the rented equipment at any time throughout the reasonable useful lifetime of the equipment, which is generally five years.**
- **Medicare will not pay for the replacement of capped rental items prior to the reasonable useful lifetime due to irreparable wear resulting from day-to-day usage.**

In summary, the DMEPOS supplier <u>must</u> provide quality equipment, not necessarily new equipment that is expected to last throughout the 5-year reasonable useful lifetime.

Enteral/Parentral/IV Therapy

3. With regards to the September 9th publication titled *Request for Refill-Documentation from Region A*, please clarify the following:

Part one written document: For items that are delivered to the beneficiary's home, would the delivery ticket suffice as to the written document? Most of the items required are already included in the delivery ticket because they are required by the proof of delivery instructions in the manual.

- Beneficiary's name
- A description of each item or of each type of item that is being requested (e.g., diabetic testing supplies, inhalation drugs, nebulizer accessories, etc.); a list of each separate item is not required
- A statement that the beneficiary is requesting a refill of the items
- Beneficiary signature (If signed by a caregiver, indicate relationship to beneficiary)
- Date of signature

Part two-phone conversation: Most providers' databases have a note section where this type of communication can be documented. Would the beneficiary's name have to be in the actual note, or would it suffice to be in the notes section of that specific patient, provided all other elements required were in the note?

Part three-unable to get a hold of patient: The supplier has made several attempts to get a hold of the patient regarding their next delivery and has not been successful. For therapies that would put the patient at grave medical risk by missing a dose, for example inotropic therapy or pain management, what advice do you have for providers? Suppliers must ship according to

the physician orders/prescriptions they have on file nor would a supplier put the patient in peril. Under these circumstances, the pharmacy may well decide to ship the next dose to ensure continuity of care, and would get the signed delivery ticket for proof of delivery. There needs to be an assurance that suppliers are not at risk during an audit in these scenarios.

ANSWER:
<u>Part 1:</u> For items delivered to a beneficiary's home, a delivery slip would <u>not</u> be appropriate documentation of a request for refill. The purpose of the request for refill is to determine whether the beneficiary needs more supplies before the delivery is initiated.

Part 2: Concerning phone conversation, the beneficiary's name must be clearly linked to their request for refill response.

Part 3: Response: Many of the DME MAC LCDs contain the "must check" requirements for need prior to shipping. These requirements are based on the Program Integrity Manual (Internet-Only Manual 100-8) Chapter 4, Section 4.26.1) and exceptions cannot be granted.

Respiratory Care Equipment/Oxygen Therapy

4. Regarding the oxygen policy under Group I criteria (Revision effective date 1/1/2010), number 3 states "a decrease in arterial oxygen saturation more than 5% for at least 5 minutes taken during sleep". Does the 5% have to be based on the mean or 5% between the highest and the lowest? In addition to the statement about the 5% does the patient also be 88% or below or can it be any sat with a 5% decrease?

   ANSWER: For Group 1 criterion 3, the 5% decrease is based on the highest and lowest values, not the mean. The policy does not require that the saturation be 88% or less during sleep. However, it would be rare for a patient with a sleep saturation greater than 88% to have symptoms or signs related to hypoxemia that would qualify the patient for coverage of home oxygen. Also, when the saturation is reported as greater than 88% on the CMN, the claim will edit and deny at the initial determination. In that situation, the supplier would need to request a redetermination and submit detailed records documenting the medical necessity in the individual patient.

5. Per the RAD LCD, an E0470 or E0471 is covered for CSA if significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed is documented. What is considered acceptable documentation showing significant improvement?

   ANSWER: Improvement of sleep-associated hypoventilation would usually be documented by a significant decrease in central apneas while the patient is on the bi-level device and being monitored in a facility setting as part of a split-night sleep study or a separate titration study.

6. The PAP policy states in order for a patient to receive a 5 year RUL replacement there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. Is there a time frame as to how far back this face-to-face can be (i.e., 1 year, 6 months)?

ANSWER: No, there is no specific time frame established. The policy simply states:
For beneficiaries who received their device while enrolled in Medicare, if a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

7. The patient has been using and benefiting from use of a PAP for over 6 years. Private insurance purchased their machine. The patient enters Medicare FFS on July 1, 2010. On August 14, 2010 their PAP device stops working and they request a replacement PAP device. They saw the physician on 4/1/10. The physician notes they are using and benefiting from the machine. The patient has been using the machine faithfully for the past 6 years. They cannot sleep without it.

BENEFICIARIES ENTERING MEDICARE:

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories; and,
2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:

    - The beneficiary has a diagnosis of obstructive sleep apnea; and,
    - The beneficiary continues to use the PAP device.

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If either criteria 1 or 2 above are not met, the claim will be denied as not reasonable and necessary.

In these situations, there is no requirement for a clinical re-evaluation or for objective documentation of adherence to use of the device.

The policy states they must have a face to face encounter since going FFS Medicare. This has not occurred. What are our options?

- Dispense with an ABN and hold patient responsible for all claims up till they see their physician?
    i. ie. Setup 8/14/10 sign ABN, doctor can't see patient until 12/1/10.
    ii. Bill 8/14/10 with GA modifier and no KX modifier.
    iii. Bill 9/14/10 with GA modifier and no KX modifier.
    iv. Bill 10/14/10 with GA modifier and no KX modifier.
    v. Bill 11/14/10 with GA modifier and no KX modifier.
    vi. See physician 12/1/10- doctor notes using and benefiting from PAP therapy.
    vii. Bill 12/14/10 with KX modifier

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- Setup 8/14/10 with ABN that states policy requires you to see the physician since electing FFS Medicare.
    i. Hold claims until 12/1/10. Verify patient saw physician and you receive notes that confirm patient is using and benefiting.
    ii. ii. ON 12/2/10 - Bill 8/14/10, 9/14/10, 10/14/10 and 11/14/10 claims with KX modifier and no GA modifier.

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The patient should not be penalized for not seeing a physician since going Medicare primary on 7/1/10 when they don't know the rules, were just in to see the physician on 4/1/10 and all appears to be going well with their therapy.

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement device or accessories, the supplier may add the KX modifier only if both of the criteria listed in the Indications and Limitations of Coverage and/or Medical Necessity for Beneficiaries Entering Medicare section have been met.

The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of FFS Medicare enrollment.

ANSWER: The PAP LCD describes coverage requirements for two groups of beneficiaries with respect to replacement devices:

1. **Beneficiaries who received their device while enrolled in Medicare; and ,**
2. **Beneficiaries who received their device prior to Medicare enrollment.**

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For beneficiaries who received their device while enrolled in Medicare, if a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and

benefit from the PAP device. There is no requirement for a new sleep test or trial period.

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. **Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories; and,**

2. **Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:**

    a. **The beneficiary has a diagnosis of obstructive sleep apnea; and,**

    b. **The beneficiary continues to use the PAP device.**

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If either criteria 1 or 2 above are not met, the claim will be denied as not reasonable and necessary.

In these situations, there is no requirement for a clinical re-evaluation or for objective documentation of adherence to use of the device.

Prosthetics/Orthotics

8. Does the "limiting charge", which restricts non-participating physicians from balance billing the beneficiary more than 15% above the approved Medicare amount, also apply to Orthotic and Prosthetic providers?

ANSWER: Medicare's limiting charge regulations are located in the Code of Federal Regulations (CFR) at title 42, part 414, section 48 (42 C.F.R. 414.48).

If a non-participating physician/supplier does not accept assignment, then Medicare pays the beneficiary directly and the non-participating physician/supplier may bill the beneficiary up to the limiting charge amount, which is 115% of the fee schedule amount for non-participating physicians/suppliers. However, the limiting charge regulations do not apply to DMEPOS items provided by DMEPOS suppliers.

9. When Medicare is the primary payer, are suppliers of Orthotic and Prosthetic services, who submit *non-assigned* claims, limited in the amount they can balance bill the beneficiary?

ANSWER: Please refer to the response provided to question 8.

Rehab Equipment

10. How will Medicare know that a replacement wheelchair part is for a Group 3 wheelchair (which should be paid at a higher allowable) and not for a Group 2 wheelchair (which should pay at the CIB rate)?

ANSWER: Please refer to Medicare Learning Network (MLN) Matters article 1035 which states the following:

Modifiers for HCPCS Accessory or Supply Codes Furnished in Multiple Product Categories -

The KG, KK, KU, KW, and KY modifiers are modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public use charts found under the supplier page at:

http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf

11. According to the Wheelchair Options and Accessories LCD the adjustable arm height option (E0973, K0017, K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms and the patient spends at least 2 hours per day in the wheelchair. The wheelchair bundling table in the policy article has K0020 listed as an included item in column II for power wheelchairs. With the RAC audits specifically identifying "wheelchair bundling" as an area of review please confirm that K0020 is a separately billable item at initial issue on a power wheelchair.

ANSWER: Yes, K0020 is separately billable at the time of initial issue of a power wheelchair; the HCPCS code bundling table will be corrected.

Ostomy/Urological/Medical Supplies

No Questions Submitted.

Diabetic Monitoring and Supplies

No Questions Submitted.

Documentation/Regulatory/Miscellaneous/Other

12. At the Medicare conference, Dr. Oleck mentioned Medicare is seeking to initiate the need for a face-to-face visit/evaluation prior to the ordering of all DME. What is status and how is this to be relayed in the billing process? What will be the expected documentation components?

ANSWER: A provision in the Affordable Care Act gave CMS the ability to require that a face-to-face evaluation by a physician be conducted prior to dispensing specified items of DME. It would not apply to all DME items. It would require that CMS go through the formal Federal Register rule-making process. Nothing has been published on this yet.

13. If a denial is received and the claim needs to be sent to redeterminations, do we need to attach medical necessity documentation even if the original denial and review is not related to medical necessity?

ANSWER: Suppliers should submit all pertinent supporting documentation with the request for redetermination. Although the claim denial and reason for request of the redetermination may not be specifically related to medical necessity, the reviewer may need to determine if medical necessity requirements have been met. Therefore, it is recommended that medical necessity documentation be submitted with all requests for a Redetermination.