July 2013 Questions

EDUCATION

1. Other regions give the DCN number on the IVR, and use voice response rather than manually keying a response; can JD C add this as well?

   Response: CGS continually improves its provider self-service tools, including the IVR and myCGS. These items will be taken into consideration for future updates.

2. If an audit is sent through multiple levels of appeals and the delay in processing results in subsequently denied rental months to go past timely filing, what is our recourse to get those dates of service paid once the appeal is found favorable?

   Response: A pending audit does not waive timely filing requirements.

3. If a system error causes a wrong date to be printed on a patient's medical records, will Medicare accept them if the technician corrects and dates the system printed date? (Example: Due to an error at the sleep lab, the date printed on the sleep study was 6/1/2004, when in reality; the test was performed on 6/1/2013. The system was not able to be overridden to enter the correct date. Does the facility have to perform a new test once the system error is corrected, or will it be acceptable to have someone cross off the hard coded date and make a correction?)

   Response: Changes to medical records must follow the CMS guidance in the *Program Integrity Manual*, Chapter 3, Section 3.3.2.5.

4. ADMC - are the nurses required to review the complete documentation prior to denying claim?

   Response: Yes. Remember that ADMC is not a "claim" rather it is just a review of information pertaining to the R&N criteria. There may be other payment requirements that will affect the determination of the actual claim when it is submitted

5. On the new face-to-face requirement does this mean that the initial claim is all that requires the face to face? What if the patient goes to another supplier since a new order is required would another face to face be required as well?

   Response: Yes. For items on the list requiring a WOPD and F2F examination, claims based on prescription (order) dates on or after July 1, 2013 must comply. A new prescription is required by Medicare:

   - For all new items or initial rentals
   - When there is a change in the order for the accessory, supply, drug, etc.
   - On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy or when required by state law
   - When an item is replaced
   - When there is a change in the supplier

HME

1. We have received a same/similar denial for a patient that received the same HCPC previously but the item has not capped out. Why would this deny if the CMN is on file but no claims for the current month have been paid? For example, patient had K0006 paid for in 2012 for 2 months. Claim is submitted for later in 2012 and denies for same or similar. Is there a way to keep this from auto denying? New documentation is received and new CMN would need to be loaded.

   Response: There is not a blanket answer that can apply to all break in service situations. Suppliers should provide as much information as possible utilizing the claim narrative fields. Each claim will process individually, and any edits will need to be resolved.

2. How long are CMN records kept on file?

   Response: Since taking over the Jurisdiction C contract, no CMN records have been purged. There are no plans at this time to purge CMN records in our local system.

3. When we receive denials for same/similar and then file a redetermination, we are often asked for pickup tickets. These documents do not exist in our records and most times there is no way for us to obtain a copy. Why are we being asked for this? If there is a CMN record on file and 13 months have not been paid, why does CGS care who the provider was?

   Response: Medicare guidelines provide that payment is due to the supplier whose supplies are actually used by the beneficiary. The *Program Integrity Manual* requires the contractor to conduct a factual inquiry on this issue (see CMS IOM Pub. 100-8, Chapter 5, Sections 5.11 and 5.12).

4. Is new medical documentation necessary for replacement of DME after 5 years useful life other than ongoing need documented within last 6 months?

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Response: Yes, there must be a new order and/or CMN. If replaced after July 1, 2013, it must meet the requirements for the F2F and WOPD.

5. Is there going to be a national auditor for DME claims?

   Response: CMS is going to designate a national DME Recovery Auditor.

6. A patient received their capped rental DME prior to January 1, 2008 and elected to continue renting under the old capped rental rules. The provider continues to bill the maintenance and servicing fee every 6 months as allowed under old guidelines. The last MS claim was paid April 1, 2013. The patient presents June 2013 requesting replacement equipment since it is past the 5 year useful life. Does a provider have to wait for 6 months past the last MS payment to replace the equipment; assuming documentation and medical necessity guidelines are all met. Meaning the patient cannot receive replacement equipment until after 10/1/13, correct?

   Response: If the new claim is from the same supplier who is billing M&S, the date of the last M&S will not affect the new claim. The new claim will be processed based on the Reasonable Useful Lifetime of the most recent capped rental on file. If the new claim is from a different supplier, 6 months must elapse from the last MS claim to the initial claim of the new capped rental.

RESPIRATORY

1. If a supplier has a patient on PAP who qualifies with initial F2F, sleep study, etc... and 2 months into the rental realizes the physician who signed off on the interpretation of the sleep study was not board certified. Upon realizing this, the provider has another physician who is board certified to complete the sleep study interpretation. Does the provider have to refund the first two months paid and start all over with a date of service after the signature of the board certified sleep study interpretation? Assuming all other qualifications are met.

   Response: Yes, the supplier should refund the first two months of payments because the policy requirements were not met.

2. If patients on oxygen stationary concentrator and portable for anything less than 36 months and you set patient up on stationary and POC or stationary and OCGE does the port (POC or OCGE) start an initial rental period and cap at 36 months or do you get the balance of what has already been paid on the portable (gaseous)?

   Response: Remainder of payments. Oxygen payment is "modality neutral" so switching portable systems would not start a new initial rental period.

3. On an oxygen audit Medicare denied for RX that states RA but without mention of "at rest". Can you appeal?

   Response: Yes, you can appeal this claim denial.

4. The Medicare Local Coverage Article for Nebulizers, (A24944) says: "For a refill prescription, payment of a dispending fee will be allowed no sooner than 7 days before the end of usage for the current 30 day or 90 day period for which a dispensing fee was previously paid." This seems to contradict the Medicare Nebulizer LCD (L11499), which says, for delivery of refills we must deliver no sooner than 10 calendar days prior to the end of usage for the current product. Can you please clarify?

   Response: Payment of dispensing fees and the time lines involved is different from the time frames outlined for contacting a beneficiary and providing the refill.

5. Patient goes from Medicare to Medicare Advantage on oxygen therapy. They have met all the Medicare guidelines for proof of delivery and medical documentation from their original delivery when first on Medicare. If a patient then switches back to traditional Medicare, is new medical documentation and proof of delivery required?

   Response: No. For items started in fee-for-service Medicare, transitioned to Medicare Advantage and then back to FFS Medicare, FFS Medicare payment resumes where it left off (i.e., the next rental month). See Jurisdiction C article entitled "Break in Service Guidelines for Medicare Advantage Plan Enrollment – Correction to the *DME MAC Insider*" (June 29, 2010). Example:

   a. Fee-For-Service Medicare paid 4 oxygen rental months then the beneficiary moved to an MA plan.

   b. Beneficiary remained in MA plan for 6 months and the MA plan pays for the oxygen rentals.

   c. Beneficiary returns to FFS Medicare. Oxygen payments resume with the 5th month rental payment.

6. Medical documentation in office visit notes describes need for oxygen therapy. However, no diagnosis is listed on the office visit notes. Can a visit note with documentation of chronic lung condition as diagnoses outside the 30 day visit period be used in conjunction with the 30 day visit note to justify oxygen? If so, is there a timeframe in which the diagnoses documentation would need to occur?

   Response: Yes, as long as it can reasonably be determined that the disease process described in previous notes is the same "chronic, severe underlying lung disease" resulting in a qualifying blood gas study. Generally a note from the previous 6-12 months would be acceptable.

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7. If a patient is discharged from the hospital on oxygen, but did not see their regular physician within 30 days prior to the initial date, are the hospital records acceptable to fulfill this requirement? (Region B is accepting them.) In what circumstances would these records not be acceptable?

   Response: Hospital records from the in-patient treating physician, even if not the beneficiary's regular physician, are acceptable to meet the requirement for a physician visit within 30 days prior to the initial date.

   In addition, blood gas studies must be conducted within 30 days prior to the initial date. Studies conducted during a hospital stay are acceptable as long as the beneficiary was in the "chronic stable state" and not during an acute exacerbation of their underlying chronic lung disease.

8. Medicare replacement after 5 years. There is some confusion on if a new dispensing order is required when equipment is replaced. Does CGS require a new dispensing order? If so, can CGS direct the council on where this is cited as a requirement?

   Response: The *Medicare Benefit Policy Manual*, Chapter 15, Section 110.2.C stipulates that a new order and/or CMN is necessary for replacement items:

   Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

REHAB

1. What model number should be indicated on the DPD when the beneficiary is receiving an upgrade?" "The MN PMD or the Upgraded PMD?

   Response: Either one may be used.

MEDICAL SUPPLIES

1. If a patient requests additional disposable supplies above what is reasonable and necessary, how should we bill this to Medicare to get the PR denial since overutilization is no longer a valid reason for ABN?

   Response: An exception to issuance of a routine ABN is found in the *Medicare Claim Processing Manual*, Chapter 30, Section 40.3.6.4.C and specifically addresses utilization. Section 40.3.6.4.C states:

   C. Frequency Limited Items and Services - When any item or service is to be furnished for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a national coverage decision or on the basis of the contractor's local medical review policy (LMRP), because all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances, the notifier may routinely give ABNs to beneficiaries. In any such routine ABN, the notifier must state the frequency limitation as the ABN's reason for expecting denial (e.g., "Medicare does not pay for this item or service more often than **frequency limit**").

   Response: Suppliers have two options for submitting claims for overutilization:

1. Split Claim Lines: List the reasonable and necessary units of service, along with the appropriate modifiers, on one line and the not reasonable and necessary units of service on the second line with a GA modifier.

2. Upgrade modifiers: Suppliers may use the upgrade modifiers to indicate the reasonable and necessary units on one claim line and the not reasonable and necessary units on the second line as an upgrade.

   Two articles are available to assist with proper billing of upgrades. See "Revised - Use of Upgrade Modifiers (A50533)" in the Medicare Coverage Database (MCD) at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Enter A50533 in the Document ID field. In addition, use of upgrade modifiers specifically for glucose monitor supplies is addressed in the article entitled "Glucose Monitor Supplies – Use of Upgrade Modifiers." Search Document ID A50376 in the MCD at the link listed above.

DOCUMENTATION

No questions submitted

ENTERAL/IV

No questions submitted

CB

1. If you grandfather an oxygen patient and they change modalities e.g. Concentrator to Home Fill, do you have to move patient to a contracted provider or can you revise the CMN and bill the additional code for the Home Fill compressor and continue billing as a supplier under the grandfather condition?

   Response: Question should be directed to the CBIC.

Revised September 30, 2013