Jurisdiction C Council

April 2011 Questions: *Final*

EDUCATION

1. If a delivery ticket has a print date at the top of the form that is computer generated, and the patient signs and dates separately when the item is delivered, should the supplier cross through the date at the top?

   a. If the patient signs but does not date a document, is it ok if the person delivering the item signs and dates below the patient signature to document the date received?

   Hoover: For Proof of Delivery, it should be clear from the delivery documentation the date that the beneficiary (or their caregiver) received the equipment.

2. HCPCS A4402 (lubricant) is billed per ounce. If the patient does not want individual packets of lubricant, could this code be billed, and if so how often?

   Hoover: The UOS is "per ounce." If 5 oz. are provided, 5 UOS are billed. The amount billed would need to be justified in the medical records.

RESPIRATORY

1. In reference to PAP, we would like to know if the clinical evaluation we received would meet the PAP policy pertaining to a beneficiary entering Medicare. The patient received a CPAP in 2005 under private insurance. The physician's original order in 2005 indicated a diagnosis of OSA and an ICD-9 code 780.53. There was also a qualifying sleep study in 2005. In 2011, the patient became Medicare eligible and in light of the PAP policy, the patient scheduled a face-to-face evaluation with her physician. We received a copy of the office visit dated 2/25/11 (see attached) and under "Past Medical History", the physician indicated: "Sleep apnea; on CPAP provided by (name of DME company)." We also received a new order for a CPAP with the diagnosis code of OSA 327.23. Will this documentation be adequate to support the requirements per the PAP LCD?

   Hoover: Would need to see the notes; however, according to the LCD:

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

2. In reference to PAP, one of our pulmonologist referrals (Medical University of South Carolina) is questioning the calculation of the AHI / RDI and the statement that "for purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the AHI / RDI." The physician stated:

   > This is interesting though because ICSD-2 defines OSAS by RDI, i.e., apneas + hypopneas + respiratory effort related arousals. It clearly states that RERAs are to be counted as a part of RDI and OSAS is defined by apneas + hypopneas + RERAs per hour of sleep. In fact, we use an ICSD-2 code to indicate a diagnosis of OSAS (327.23) on our charge sheets and as per this definition of OSAS, RERAs are included in the definition. You may want to ask CIGNA to look at the ICSD-2 manual definition of OSAS.

   Can you please clarify?

Hoover: The AHI/RDI are defined in the national coverage determination (NCD). Should a provider wish to have RERAs added as a qualifying event in the calculation of the AHI/RDI, they should request of CMS an NCD reconsideration.

3. The Revised MLN SE1103 says the following on page 4 of 5 with regards to the Oxygen MS:

   The payment covers all maintenance and servicing through the following 6 months that is needed in order to keep the oxygen equipment in good working order. A single payment ($65.93 for dates of service January 1, 2011, through December 31, 2011), is made per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment), *regardless of when the maintenance and servicing is performed during each 6-month period, and regardless of how often the equipment must be maintained and serviced. The supplier is required to make at least one maintenance and servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period.* These changes are discussed in Change Request (CR) 7248, issued by CMS on January 24, 2011.

   Based on the sentences italicized above, when billing maintenance for oxygen equipment, what date should be used as the service date? Assuming service is provided within the required period, should providers use an anniversary date, or the actual service date that ties to a delivery/service ticket?

   Hoover: As referenced in CR 6990, the DOS on the claim should be the actual date of M&S, which must be in the first month of the 6 month period. Only for a few specific exceptions can it be outside of that first month and supplier convenience is not one of the exceptions per CMS.

4. If a patient has placed on Oxygen during a Hospice stay, and the hospice stay is revoked, would there have to be a new order /CMN when the patient starts back on standard Medicare?

   Hoover: Yes.

   a. Would the testing in the hospice stay be an acceptable testing if it was originally done in physicians' office or under the supervision of a physician?

   Hoover: Yes. The test would be acceptable if it meets the conditions for a qualifying test and testing entity in the LCD, and all other criteria have been met.

REHAB

1. A patient is receiving a manual tilt in space but needs a power tilt added due to the fact that the patient does not have room in the home for a power base. Additionally, the situation is complicated because the patient is left alone for lengths of time and is unable to complete independent weight shifts. Would a power tilt added on to a manual tilt in space be a covered item?

   Hoover: Yes, if medical necessity is adequately documented.

2. If a patient has an existing power wheelchair with a captain's chair and subsequently suffers from skin breakdown and needs a skin protection/positioning cushion we know the cushion is not payable with a van seat. If the van seat is removed and a rehab seat is added, when the cushion and rehab seat is billed, would they deny because the base was a van seat base?

   a. Can you recommend the best way to bill this successfully so that all necessary information for effective claim processing is received by the processor with the initial claim?

   Hoover: As long as the appropriate codes are billed and the supplier retains documentation of the conversion and medical necessity, it should be covered.

3. A power wheelchair that is coded as a K0823 also has an option for a seat elevator (which is non-covered). Could the patient be billed for the seat elevator option with an ABN?

   Hoover: No. ABNs are not required for statutorily non-covered items.

4. A patient has ALS and initially receives a complex power chair, then the patients' condition significantly declines within just a few months and now needs a head array. Would the patient need a **new** face to face with their physician if they are already being seen by a physical therapist and a therapy note is completed explaining the need which the physician reviews and signs off on it?

   Hoover: No, there would not need to be a new face-to-face; however, there would need to be adequate

documentation in the physician's records justifying the medical necessity for the new head array accessory. This may necessitate an office visit or, at a minimum, treating physician concurrence with the physical therapist's evaluation.

5. If the supplier leaves off just the manufacturer's information for batteries on the detailed product description can they:

   a. Print it on the ticket after the physician has signed the order?
   b. Is it required to get an initial and date from the physician for the change?
   c. Do they need to get a completely new order?

   Hoover: The supplier must not modify or alter a completed and signed detailed product description. If an error or omission is noted, the physician may correct it then initial and date the additional information. As an alternative, a new document may be prepared, signed and dated.

DME

1. If a beneficiary initiated a capped rental prior to 1/1/2006 under the old capped rental guidelines, Maintenance and Service can be billed to Medicare twice a year (regardless if service is done or not). When maintenance is billed accordingly, claims for replacement equipment end up being denied as same or similar, and customer service instructs providers that replacement equipment is not eligible until 7 months after the last paid maintenance claim.

   For example, a beneficiary rented a CPAP on 7/8/05. After the item capped the provider was billing M&S every six months. The last M&S was billed on 4/8/10. After the CPAP reached the reasonable and useful lifetime of 5 years, the beneficiary may have a broken device or requests a different CPAP and returned to the physician and had another face-to-face visit documenting continued use and benefit for an ongoing diagnosis of OSA. A new CPAP was furnished on 9/9/10. The replacement claim is consistently denied as same/similar. We are told that a new rental period cannot begin until 7 months from the last M&S bill.

   a. Is this a correct instruction or a possible education issue for the CSR and claim processing staff?

      Answer: This is a correct instruction. The M&S payment covers the item from the DOS through the next six months.

   b. We expected that the identification of a replacement claim would supersede only future maintenance billing, and would be payable based on the merits of the useful lifetime expectancy. How can these replacement claims be billed so that they avoid the process of same or similar denials?

      Answer: The last M&S can be refunded.

2. The CIGNA voice response unit will tell you the initial date on CMN for equipment but the last date billed does not appear to reflect the last bill date for M&S. In our experience we have to call the customer service and ask. If the answer to the questions above require providers to wait 7 months after the last maintenance was billed to obtain a replacement piece of equipment, can the IVR be programmed to query maintenance and service claims to calculate last date billed? Or can a disclaimer be added to remind providers that they must call a CSR to obtain maintenance and billing information?

   Hoover: The 5 year reasonable useful lifetime (RUL) runs from the initial date of service. The RUL does not get extended by the old capped rental 6 month maintenance and service cycle.

DOCUMENTATION

1. Suppliers encounter situations where they receive notification from hospices that the patient is revoking their hospice benefits effective with a date given. They will continue the use of equipment used during their hospice stay which will require billing of the DME to the MAC. Many of these patients are sedentary and cannot go to a physician's office for a face to face assessment.

   a. What is required for continued patient use of DME equipment including oxygen if it was initially started during the hospice stay?
   b. What is required for continued patient use of DME equipment including oxygen if it was initially started under the MAC and then treated as a break in service during the hospice stay?

   Hoover:
   a) There is no automatic continuation of oxygen upon exiting hospice, unlike the provisions that apply upon

exiting a Medicare managed care plan. The beneficiary must meet all requirements as if they are a new, initial claim to Medicare fee-for-service.

b) Standard break in service rules would apply. In the case of oxygen, it is likely that payment would resume at the point it left off since a change in medical necessity for long-term oxygen therapy is extremely rare.

ENTERAL/IV

There seems to be inconsistency among the DME MACs regarding billing for a denial for vancomycin administered with a pump.

Jurisdiction A Ask-the-Contractor Teleconference - June 8, 2010: "Vanco is a statutorily excluded drug and should be billed with a GY modifier to indicate noncoverage" "the pump and supplies would be billed with a GA modifier (assuming a properly issued ABN was signed) as they are not statutorily excluded."

Jurisdiction B DME MAC News You Can Use! - August 20, 2010: Title is "Billing for Denial of Vancomycin Administered Via an External Infusion Pump." "if the drug is not listed in the external infusion pump medical policy, suppliers must execute an…ABN…for all items (drug, pump and supplies)" "If suppliers have properly executed an ABN, the GA modifier should be appended to all claim lines."

Jurisdiction C Notice - August 23, 2010: Contains the same instructions as the Jurisdiction B announcement.

Jurisdiction D Notice - undated by web address includes date of November 11, 2007: Title is "VANCOMYCIN ADMINISTERED VIA AN EXTERNAL INFUSION PUMP." Citing sentences from the NCD Manual, the notice says, "when J3370, Vancomycin, is billed with an external infusion pump, both J3370 and the pump will be denied as non-covered." The denial will be a patient responsibility (PR) denial."

DAC D/Noridian Q&A from 2/5/08, Question #6:
Question: "Will we still need to obtain an ABN?"
Answer: "No, a Vancomycin is always non-covered and is always a patient responsibility."
Question: "Would we then bill with the GAGY modifier?"
Answer: "It is never appropriate to bill with both a GA and GY modifier on the same claim. The GA means that an ABN has been obtained, while GY states that a service/item is statutorily non-covered, which means that an ABN is not required." (found at http://www.dacd.org/QA_2008.html)

We attempt to summarize what the contractors communicate as follows:

	IS ABN REQUIRED?		MODIFER WITH NO ABN		MODIFIER WITH ABN	
PUMP	A: Yes C: Yes	B: Yes D: No	A: GZ C: GZ	B: GZ D: GY	A: GA C: GA	B: GA D: n/a
DRUG	A: No C: Yes	B: Yes D: No	A: n/a C: GZ	B: GZ D: GY	A: GY C: GA	B: GA D: n/a
SUPPLIES	A: Yes C: Yes	B: Yes D: No	A: GZ C: GZ	B: GZ D: GY	A: GA C: GA	B: GA D: n/a

Question 1: Is provision of Vancomycin IV drug administration in the home statutorily excluded?

Hoover: No. Administration of vancomycin via external infusion pump is considered not reasonable and necessary, not statutorily non-covered.

Question 2: Will the four DME MACs collaborate to issue identical instructions on billing for denial of vancomycin administered via an external infusion pump?

Hoover: Yes, the medical directors have discussed this issue and are in agreement with the following guidance:

1. The legislated benefit is durable medical equipment; therefore, the coverage is for the external infusion pump (i.e., the DME), not the infusion drug. If there is no pump, there is no coverage under this benefit. Therefore, when vancomycin (or any other infusion drug) is billed alone without a pump, there is no benefit and the drug will be denied as statutorily non-covered. The exclusion is statutory, applies to both the drug and any associated supplies and use of the GY modifier is appropriate. No ABN is required.
2. If there are both a drug and an external pump and the drug is not listed in the External Infusion Pump LCD as requiring a pump, then the drug and pump and any associated supplies deny as not reasonable and necessary. Since this is an R&N denial, a GA should be used if an ABN has been properly completed (and a GZ if not).
3. If there are both a drug and an external pump and the drug is listed in the External Infusion Pump LCD as requiring a pump, then the medical necessity conditions in the LCD must be met or the drug, pump and any associated supplies deny as not reasonable and necessary. Since this is an R&N denial, a GA should be used if an ABN has been properly completed (and a GZ if not).

Note that the national coverage determination (NCD) on vancomycin, while using the term "not covered", must be considered in the context of the above discussion. If the vancomycin is billed without a pump, it would be denied as non-covered (no benefit). If billed with a pump, it would be denied as not reasonable and necessary.

O&P

1. There is a provision to allow for specific O&P items in a Part A stay. However, if a back brace must be fitted immediately post-op, is that billable to the MAC? Or should the brace be billed to Part A as incident to the surgical procedure?

   Hoover: DMEPOS may be provided within two days of discharge for "fitting and training" then provided to the patient at the time of discharge with the DOS = Date of Discharge. The practice of fitting a brace prior to admission for application immediately post-op then billing to the DME MAC is considered incorrect billing. The brace in the situation described should be billed to hospital or SNF since the orthosis is paid as part of the Part A charges for the hospital or SNF.