

## Jurisdiction C Council

### October 2009 Questions

#### EDUCATION

1. Is it possible to add the patients name to the IVR for information on recoupments. It currently only gives Medicare ID #.

**CGS will take this into consideration as a future IVR enhancement.**

2. Has there been any further discussion on how to automate the CO176 denials to allow for claims to go automatically through without extending the cmn when payments have been recouped?

**CGS technical staff has had several discussions on this issue. The CO176 denial applies to multiple situations, not just based on recoupment. Currently, claims editing for capped rental items that edit for dates of service outside the 13 months will suspend for manual review if a narrative is submitted.**

#### RESPIRATORY

1. CERT has been sending Additional Documentation Requests (ADR) for items that are not contained in the LCD. If the DME provider is unable to produce this documentation (either because the physician does not have this documentation or is unwilling to provide this documentation), CERT is asking the DME MAC to recoup the payment for the DOS audited. An example of such an ADR for oxygen (E1390, E0431) is as follows: "Need clinical documentation (office visit notes, progress notes, in-patient notes) 12 months prior and 6 months after DOS audited to support medical management of pulmonary disease requiring oxygen therapy and supporting beneficiary's continued use and need for oxygen as billed for DOS audited."

We can usually produce documentation supporting the beneficiary's continued use through our oxygen deliveries, concentrator checks and exchanges that we had performed surrounding this DOS and CERT stated that these would be acceptable. We submit both the initial and

recertification (lifetime) CMNs, sometimes from several years ago. We also provide the date of the patient re-evaluation done prior to the recertification. In reference to documentation of clinical documentation 12 months prior and 6 months after the DOS audited, this is where we are having challenges. Clearly, this is not required per the LCD. Even if we have all the other documentation but we could not submit any documentation that the patient was seen within this time frame, CERT would ask that the payment be recouped. In previous council meetings, CIGNA had encouraged DME providers to aggressively appeal CERT denials. Is this type of CERT-triggered denial one that CIGNA would overturn through the appeals process?

**All CMS contractors are required to follow coverage, coding and documentation criteria in NCDs, LCDs and program instructions (i.e., CMS Manuals). If a supplier believes a decision by a contractor is not based upon published policy it is the suppliers right to appeal.**

2. Follow up from previous CIGNA Council Q and A (July 2009) under Respiratory. What is the final resolution to this question?

First Coast Service Options, the Medicare Part B contractor for the state of Florida, has jumped the gun by about six months and has required as of **June 30, 2009** properly credentialed physicians (e.g. board certified) to review and interpret sleep studies. In addition, First Coast has added the Epworth Sleepiness scale requirement in the initial evaluation in its LCD for sleep studies. Under the DME MAC's PAP LCD, properly credentialed physicians to interpret facility-based sleep studies are required on or after **January 1, 2010** and the Epworth Sleepiness scale is just one of the elements of the initial evaluation. As a DME supplier providing a PAP in Florida, what would be the definition of a "Medicare covered" sleep test as of 6/30/09? If the sleep study criteria under the Part B policy are not met but the criteria under the DME MAC's policy are met, can a DME supplier consider the sleep study as a "Medicare covered" sleep study?

Reimbursement for sleep studies is governed by the coverage and payment rules of the local Part B or A/B MAC contractor. Reimbursement for the PAP device is based on the coverage and payment rules of the DME MAC. The DME MACs will accept facility-based PSGs from non-credentialed physicians in Florida until the DME MAC LCD deadline for credentialing of 1/1/2010.

3. PAP review period claims submission & billing: Please clarify if the capped rental billing period extends by the amount of time the supplier waits for the patient to visit the doctor to verify they meet qualifications. We have been unable to find documentation that clearly outlines this and what have found, can be interpreted both ways.
  - a. If the patient takes 6 weeks after the first 3 months of rent to see the doctor, are those 6 weeks included in the 13 months limit for the supplier's reimbursement so the supplier only receives 11 month reimbursement from Medicare? Or does the supplier still receive the full 13 months reimbursement from Medicare? Some suppliers are under the understanding that they MUST submit the claims for the rent of the PAP during the time period they are waiting for the patient to see the doctor. Everything we have found states they **MAY** submit claims during that time period, but must not include the KX modifier. Please clarify. (Sue Haberlock, [susan@cu.net](mailto:susan@cu.net))

**A supplier can hold claims during this period until the beneficiary becomes compliant with the PAP LCD. When the "scheduled" 13<sup>th</sup> month is reached, a supplier can ask for an extension of the capped rental period by including a narrative statement.**

4. A patient was on CPAP prior to 11/01/2008 and was compliant on the machine. When the patient goes back to the physician, the physician performed a follow-up titration only and changed the patient to BiPap. Are there any other requirements other than the physician showing in the new titration study that the CPAP was not effective? (Donna, via Teresa Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**No.**

5. Same scenario as above (initially provided before 11/01/08) but patient was NOT compliant with the CPAP. The patient moved and left no forwarding information, so we were never able to bill past the first three months of the original CPAP. The patient has now resurfaced at the physician's office and the physician did a titration study only and ordered a BiPAP. What are the Medicare requirements under this scenario? (Donna, via Teresa Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**The patient described above would need to follow the LCD in effect at the time of the initial date of service (DOS) of the CPAP device. That LCD addressed the coverage of a RAD device for the treatment of patients with OSA.**

6. A patient purchased a CPAP over 10 years ago through commercial insurance. The patient is now Medicare, went to the physician who only performed a titration only study and then ordered a BiPAP. Since the physician is requesting that the CPAP be "replaced" with a BiPAP (instead of a CPAP), what are the requirements? Can this be done as a simple replacement where the patient must have a face-to-face and the physician document OSA and compliance or, since it is a different type of equipment, do we have to start all over with a new Type I sleep study? (Donna, via Teresa Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**In this scenario the physician is ordering a higher piece of equipment, one for which the beneficiary has not previously demonstrated medical need. The patient would need to qualify under current Medicare guidelines for the BiPAP device at the time of dispensing.**

7. In the RAD policy, Central Sleep Apnea for initial coverage it states that A and B and C all three have to be met. The question is in reference to B. "The ruling out of CPAP as effective therapy if either CSA or OSA is a component of the initially observed sleep-associated hypoventilation, **and** ". The technician stated a patient clearly exhibited Central Sleep Apnea and went straight to bi-level w/back-up for titration (Actually Auto SV). The provider stated they needed to have evidence that CPAP was tried and failed or aggravated the apnea and was requesting additional information. The tech stated that this was NOT for Complex Sleep Apnea and that she was NOT going to try CPAP and a patient with Central Only Sleep Apnea. What is required to "rule out CPAP" ? It does not say that CPAP has to be tried and fail ONLY that it need be ruled out. The tech did rule CPAP out and placed the patient on Bi-Level. The patient did meet the definition for Central Sleep Apnea (A) and did improve the hypoventilation (C). (Todd Tyson, [ttyson@hitech.ntcmail.net](mailto:ttyson@hitech.ntcmail.net))

**The policy requires only that CPAP be considered and ruled out, not that CPAP was tried and found ineffective. Based on the CSA diagnosis, the physician considered CPAP to be an inappropriate treatment option and treated the patient with a bilevel device which is an acceptable action according to the RAD LCD.**

8. The Oxygen LCD revision published on 06/12/2009 was made retroactive to 01/01/2009. How can documentation requirements be published as a change on 06/12/2009 and be implemented retroactively to January 2009. How can you hold a supplier accountable in an audit (post pay, CERT); the supplier could not have known of the LCD changes/new requirements when they submitted their claims in January if the change/rule was not published until 06/12/2009? (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**CGS published a listserv article entitled “Oxygen FAQs” on October 8, 2009. Question 3 addresses this issue:**

*Q3. The Oxygen LCD includes a requirement that the patient be seen and re-evaluated by the treating physician within 90 days prior to recertification. The revision of the LCD that was released in June included a change in the coverage of oxygen if the required re-evaluation was not performed within the 90 day time frame but was performed at a later date. The previous policy stated that, in that situation, payment could be made for dates of service between the scheduled recertification date and the date of the late physician visit if the blood gas study criteria were met. The revised policy states that, in that situation, coverage would end when the Initial Certification period ended and would resume beginning with the date of the late physician visit. The effective date of the LCD revision was given as 1/1/09. Did these revised coverage criteria take effect on that date?*

*A3. Because of the short notice given for the policy revision and the change in payment rules, the effective date of this specific requirement will be claims with dates of service on or after August 1, 2009. This date is based on the June 19, 2009 public release date of the policy revision. This clarification will be incorporated in a future revision of the LCD.*

9. PAP and O2 Pre-Pay Audits: What is the percentage of Oxygen/PAP claims that are being pulled for pre-pay Audit? (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**CGS does not release information on edit parameters.**

10. The Oxygen LCD under Revised CMN states a Revised CMN is required “if there is a new supplier and that supplier does not have the prior CMN”. Does this mean when a patient changes suppliers if we obtain a copy of the previous Supplier’s CMN and it is valid we can continue to bill using the previous supplier’s CMN? (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**Per the Oxygen LCD, a revised CMN is required if there is a new supplier and the new supplier is unable to obtain the original CMN from the previous supplier. If the new supplier is able to obtain the original CMN, a revised CMN is not required.**

11. We continue to experience problems with our physicians understanding the CMN requirement to count prior cumulative months when recertifying the length of need. Request the DME MAC(s) to publish a Dear Physician letter related to length of need and the requirement to enter the total cumulative months prescribed from initial date through the current CMN period. (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**“Dear Physician” letters are not used for this type of technical information. CGS might consider a general bulletin article if the specifics of the situation are clarified with an example.**

12. Can we sell a portable oxygen concentrator to a patient that has O2 with another company and they are billing Medicare? Would provider need an ABN explaining to patient this is duplicative equipment? ([Joan@ClayHomeMedical.com](mailto:Joan@ClayHomeMedical.com))

**In this situation you would need to execute an ABN to the beneficiary and explain to them Medicare’s rules governing home oxygen therapy. If the beneficiary is fully aware of Medicare payment rules and if they choose to purchase the equipment by indicating as such on an ABN, then you may sell the equipment as an outright purchase. *(Please note that if the equipment is billed to a Medicare contractor the denial will not be deemed patient responsibility even with a signed ABN.)***

13. If a patient is currently renting oxygen equipment and wants to purchase another type of oxygen equipment without billing Medicare and we obtain an ABN (any time during the 1<sup>st</sup> 5 years on O2) can we sell the product to the patient? ([Joan@ClayHomeMedical.com](mailto:Joan@ClayHomeMedical.com))

**As with Q12 under Respiratory, you may do so with informed beneficiary consent. If the beneficiary makes an informed decision by indicating on the ABN that they do not wish for a**

**claim to be filed with Medicare, then it is not necessary to do so. As a reminder, Medicare will not pay for any contents, supplies or repairs for this equipment.**

14. Medicare rented a PAP device to purchase (13 months). The patient is now requesting and receiving replacement PAP supplies and accessories. We have begun to receive rejections for required NTE note for patient owned equipment. Wasn't it the direction of the DME MACs only to enter an NTE Note if the equipment was patient owned prior to Medicare eligibility and/or if not billed or paid by the DME MACs? (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**We would need to see examples of these claims since they are specific examples. Currently the Technical Team for Claims is unaware of any issues with NTE notes.**

15. If a patient is originally put on a CPAP per doctors orders and is moved to a BIPAP unit and then is put back onto a CPAP unit per doctors orders, what coverage criteria should be met for qualification. What timeframe should the compliance data be within and is an additional face to face required after the patient is put back onto the CPAP unit?

**The NCD allows for coverage of an initial trial of CPAP that must be completed within 3 months. The compliance metric and completion of the follow-up re-evaluation must be completed within this timeframe. Per the LCD, the only extension of the timeframe is when there is less than 30 days left in the 90 day trial period when the patient is changed from one type of device to the another. In that case, the trial may be extended for an additional 30 days.**

## **REHAB**

1. Is a provider required to employ an ATP in order to do repairs on Group 2 SPO and MPO and all Group 3 and 4 power wheelchairs? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**No.**

2. If a power wheelchair is greater than 5 years old what documentation is needed before a new one can be provided? If the only things wrong with the chair is the need for new batteries and tires can they still get a new one? What if the patient just "wants" a new one and there is nothing wrong with the power wheelchair? Is complete F2F documentation required? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**The new PMD LCD applies to the 5 year reasonable useful lifetime replacement of the old PMD that pre-dates the coding revision and recategorization of PMDs. Therefore, there is no automatic transition from K0011 to K0823. See article from October 2007 titled "Power Mobility Devices – Frequently Asked Questions" Question #7:**

**As detailed in Final Rule for Power Mobility Devices (*Federal Register*, Vol. 71, No. 65, April 5, 2006) and published in the September 2007 *Frequently Asked Questions – Power Mobility Devices* article:**

*Q7. If a new PMD is needed after 5 years of use, what documentation must be obtained? Must we start the complete process or just obtain a new order?*

*A7. All new PMD requirements must be met. Many new products are available, the codes have changed, and a patient's functional status must be assessed through a face-to-face evaluation in order to establish need.*

**When replacing a PMD after the 5 year reasonable useful lifetime is met, the beneficiary must meet all of the coverage requirements outlined in the local coverage determination (LCD) for PMDs, including a new 7-element order and face-to-face evaluation. This information will be reiterated in a future bulletin article.**

3. If a power wheelchair base is coded as a single power option wheelchair, but a multiple option is placed on it (i.e. Tilt/recline) by another mfr (at the request of the provider), where does the responsibility lie since the coding is not "approved" for that - mfr (of tilt/recline) or provider? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**The responsibility for proper coding of DME rests with supplier.**

4. Under the new LCD revision for PMDs, the DPD now requires a HCPCS narrative. How detailed must this be? Is this to be the exact narrative description of the code as defined by the PDAC? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**Yes. The LCD now requires that the detailed product description (DPD) contain the narrative of the HCPCS code as described by the PDAC. The LCD now states:**

***For the wheelchair base and each option/accessory, the supplier must enter all of the following:***

- *HCPCS code*
- *Narrative description of the HCPCS code*
- *Manufacturer name and model name/number*
- *Supplier's charge*
- *Medicare fee schedule allowance*

5. Is there a required time frame from when a physician physically sees a patient to when they go to their actual wheelchair evaluation (prescribed by the physician during his visit)? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**The LCD does not specify a timeframe; however, one would expect that the wheelchair evaluation occur in reasonably close proximity to the physician visit so that the documentation of medical necessity for the wheelchair accurately reflects the patient's condition at the time of the wheelchair evaluation.**

6. The IVR for JD C states that they can give same or similar equipment for items with a CMN or DIF. How does this affect wheelchairs that do not require a CMN or DIF? Or is this just misworded? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**The IVR does provide same or similar information on wheelchairs. Even though some items do not require a CMN to be submitted, a Dummy CMN is built in order to track payments.**

## DME

1. Chapter 5 of the CIGNA supplier manual (under the Replacement section) states: "If the equipment has been in continuous use by the beneficiary on either a rental or purchase for the equipment's useful lifetime, then the beneficiary may elect to obtain a new piece of equipment." It goes on to state: "DME MACs determine the reasonable useful lifetime of equipment, but in no case can it be less than five years." Can capped rental items (e.g., PAP, nebulizer, wheelchair, etc.) and IRP equipment be automatically replaced every five years regardless of whether the equipment is damaged or still in good working order so long as the beneficiary elects to obtain a new piece of equipment? We understand that a new physician's order is required. (Kimberly Rogers-Bowers, [Kimberlie\\_Rogers-Bowers@apria.com](mailto:Kimberlie_Rogers-Bowers@apria.com))

**Currently, under Medicare policy, a beneficiary may elect to get a new piece of equipment after 5 years of continuous use. This decision rests with the beneficiary only. A physician's order is required.**

2. Is there any update to the draft policy of E0217?

**The medical directors are working on the "Response to Comments" and hope to have the policy finalized in the near future.**

## DOCUMENTATION

1. In reference to a legible physician signature, our CMNs and prescriptions are printed from our computer system. As such, the document contains the physician's printed name, address and NPI. If we have a legible identifier for the physician signing the CMN/prescription (i.e., the physician's printed name/address/NPI) but the physician's signature is not readable, will this document be acceptable?

**The Program Integrity Manual, Chapter 3, Section 3.4.1.1.B. requires that all documents submitted to Medicare have a legible identifier. If contractor reviewers are not able to determine the author of a document through a legible identifier, the document will be disregarded.**

2. Regarding the publication: **GA -- WAIVER OF LIABILITY STATEMENT ON FILE.** *You must fully execute the Advanced Beneficiary Notice before appending the GA modifier to your claim. In order to have the GA modifier added to your claim after the initial determination, you must submit the ABN in paper to Written Reopenings.* Could you please provide us with the top reasons that ABNs are determined invalid so we can educate the provider community? (Pamela Dentino-Olson, [Pamela.Olson@Walgreens.com](mailto:Pamela.Olson@Walgreens.com))

**CIGNA Government Services does not track that information. Provider Outreach and Education does provide information on properly executed ABNs through webinars and workshops.**

3. Nursing home records - When the dispensing order is signed by the physician on record and the supplier creates a DIF using that physician but the Detailed Written Order is signed by another physician in the practice or possibly a Nurse Practitioner, is the supplier required to correct the DIF? Is the Detailed Written Order OK when it is signed by someone in the same practice even though it doesn't match the DIF physician? (Pamela Dentino-Olson, [Pamela.Olson@Walgreens.com](mailto:Pamela.Olson@Walgreens.com))

**Yes. Contractors understand that sometimes in a group practice another member of the group may see a patient and complete paperwork.**

4. Our CMNs and Detailed Written orders have the prescribing entity (MD, DO, NP, PA, CNSP) and their address and NPI printed on the document. The prescribing entity signs the document in their standard signature fashion. To try to understand the legible signature requirement we reviewed several of our prescribing physician's signatures. Each person's signature is unique and usually the written signature does not look anything like their printed/typed name. However the signatures on the CMNs/Orders we reviewed for that prescribing physician looked the same. How can CMS or the DME MACS determine a signature to be valid or invalid? Wouldn't a review of the physician's signature on an official document such as the physician medical license, driver's license, passport, social security card or etc be required first to determine their valid signature before a decision could be made to say it was invalid? (Teresa L. Camfield, [TCamfield@ppsc.com](mailto:TCamfield@ppsc.com))

**Medicare contractors are tasked with determining if a signature is legible not to determine its validity. We are currently awaiting specific guidelines on legible signatures from CMS.**

5. Are all current Medicare enrolled physicians in this system, or do they have to go on-line and sign up in this system? Also, is there any way to verify that a physician is listed in PECOS? (Terry D. Henderson, DME Services of Texas, 972-288-1663, [tthenderson@dmeservicesoftexas.com](mailto:tthenderson@dmeservicesoftexas.com))

**Not all Medicare enrolled physicians are in the PECOS system. Currently there is no system available to suppliers to verify if a physician is enrolled in PECOS.**

6. Can you please enlighten us on the whole PECOS system. We have not found a way to verify registration so how could we be responsible for something we have no way of knowing until the denial comes in? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**We are awaiting further instruction from CMS on PECOS and how it will impact DME suppliers.**

7. For providers who did not meet the accreditation deadline of October 1st, are they still able to bill for dates of services prior to October 1st?

**Yes.**

8. If a provider has capped rental equipment out to a patient and the 13 month rental period goes beyond October 1st can they continue to bill for the remaining months? (Jim Stephenson, [JStephenson@invacare.com](mailto:JStephenson@invacare.com))

**No.**

9. Is there a published frequency for trach tubes? It is no longer listed under trach supplies with a frequency. (Jennifer Halterman, [GTurner@RobertsHomeMedical.com](mailto:GTurner@RobertsHomeMedical.com))

**Medical Director will research. No recollection of a previously published frequency parameter for tracheostomy tubes.**

## ENTERAL/IV

1. Regarding ICN 09033728072000, this represents a take back of payment from CGS as the result of information obtained through the CERT process. CGS re-issued payment of this claim through a redetermination based on the same documentation provided to the CERT contractor. Does the DME MAC monitor the amount of claims reprocessed for payment based on errors made by the CERT contractor?

**Yes, that data is tracked for internal use.**

2. If a patient uses a pump for enteral feedings but is able to tolerate gravity and/or bolus how is a supplier to report the non-qualified pump status to Medicare? (Pump is used for convenience but not medically necessary as defined by the LCD). The DIF simply asks the method of feeding, not if the method of feeding meets the medical policy requirement. Currently suppliers must receive the payment and then refund the Medicare program, which is inefficient and costly. Is there a way for the MAC or Medical Directors to make a recommendation to CMS on this process? (Tom Heinrich, [Tom.Heinrich@McKesson.com](mailto:Tom.Heinrich@McKesson.com))

**The supplier would append either the GA (ABN obtained) or the GZ (ABN not obtained) modifier to the claim line for the pump. A revised DIF would also be necessary if the method of delivery has changed from pump to gravity.**