

Education

No questions submitted.

Respiratory

1. These questions are in reference to the requirement in the PAP LCD that physicians interpreting facility-based polysomnograms must now meet the credentialing requirements effective January 1, 2010. Medicare has always stated that there is no time limit or expiration for a sleep study, e.g., a sleep study that was performed June 2009 can be used to qualify a PAP patient.

- a. For a new PAP set up on or after 1/01/10, do we need to ensure that the facility-based sleep study from June 2009 was interpreted by a duly-credentialed physician?

Answer: Under the current policy language, yes; however, the DME MAC medical directors are revising the PAP policy, effective for dates of service on or after 01/01/2010. The new policy will reference 01/01/2010 as the date the credentialing requirement for the test rather than the DOS of the device. In the example you give above, a test performed in June 2009 by a non-credentialed physician would be acceptable for a PAP claim with DOS 01/01/2010 since the credentialing requirement doesn't go into effect until tests performed on or after 01/01/2010.

- b. If this information cannot be verified or the physician was not credentialed during that time frame but is credentialed now, do we now ask the patient to have a repeat sleep study?

Answer: No .

- c. Can we ask the patient to sign an ABN when it cannot be ascertained that the physician who interpreted the sleep study is credentialed?

Answer: Yes .

- d. How does the DME provider determine if the physician is appropriately credentialed? The website for the American Board of Medical Specialties requires a log in and professionals are required to pay for the information.

Answer: You can create a login for personal use on the ABMS site (<http://www.abms.org>) or request that the physician provide a copy of their credentials. The information may also be available from the American Academy of Sleep Medicine (<http://www.aasmnet.org>).

- e. What kind of documentation will a DME provider be required to present for an audit to show the physician was appropriately credentialed when the sleep study was interpreted?

Answer: Copy of the physician's credentials or copy of printout from ABMS site.

- f. If the physician was credentialed when the sleep study was interpreted but later loses those credentials, does that impact future claims for PAP and/or PAP supplies?

Answer: Only orders for new PAP devices. Existing, ongoing claims for supplies based on an order from a credentialed physician at the time of initial issue are acceptable.



- g.** Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO).JC has accreditation for "Freestanding Sleep Centers" (e.g. <http://www.jointcommission.org/NR/rdonlyres/28E7B1C6-6AC0-48A5-BACD-4391F02115C8/0/2009SLEEPHdbkwcover0309.pdf>) . . . if a hospital is JC accredited, does this apply? This JC requirement is vague. I think it is clear that a "freestanding center" needs to be accredited by either AASM or JC... but what of a hospital based laboratory, does the overarching JC hospital accreditation cover the lab as well? (Kimberlie Rogers-Bowers, Kimberlie.Rogers-Bowers@apria.com)

Answer: Yes

- 2.** PAP Compliance: 90 day objective criteria, other jurisdictions are relenting on the 90 day cutoff to allow for a few days/weeks beyond the 90 days to qualify; what is Jurisdiction C's stance?

Answer: Jurisdiction C will continue to follow compliance policies as directed by the PAP LCD.

- 3.** Nebulizer CERT Audit: Example: CERT is requesting and requiring physician documentation of the patient's pulmonary disease 12 months prior to the date of service for Nebulizer medication provided on 03/26/2009 and 6 months after the date of service; showing continued physician management of the patient's pulmonary disease that warrants the need for nebulizer medications. It is our understanding there will be published guidelines on look back periods, but we have not seen these as yet. What are providers to do when CERT is denying based on look back periods not defined? (Teresa Camfield, TCamfield@ppsc.com)

I have attached the Nebulizer LCD in effect at the time of service for this patient.

- a.** Upon review of the attached LCD; there is not a date last seen or physician face to face exam required prior to the treating physician prescribing nebulizer medications or a requirement for a patient to be seen at the time of annual recertification.
- b.** There is not a specific time for the patient to be evaluated prior to prescribing nebulizer medications or after they were prescribed. . .
- c.** CERT has the ability to request medical records based on the two excerpts from the LCD noted below (these two statements are in every LCD and I believe this standard language was added in 2002 or 2003)
- i.** LCD initial section "Indications and Limitations of Coverage and/or Medical Necessity"; read below and "For the items addressed in this medical policy," the criteria for "reasonable and necessary" are defined by the following. . .
- ii.** LCD Documentation Section: "It is expected that the patient's medical records will reflect the need for the care provided." CERT can use this to request medical records documenting medical assessment prior to prescribing the nebulizer medication and after.
- d.** PIM Chapter 5 and Chapter 3 excerpts are also noted below related to the Medical Record and Pre-Pay and Post-Pay Audit allowances

Answer: Medicare requires that payment for each claim be justified. The Medicare statutes allow the contractor to request whatever information is necessary to make a reasonable and necessary determination and substantiate payment. While contractors have traditionally focused reviews on whether coverage criteria were met for the initial DOS, it is clearly within the statutory authority of the contractor to determine that medical necessity continues to exist for claims submitted after that initial DOS.

Note: Please see attachment for the LCD and IOM examples included in Q&A. (JH)

- 4.** At the recent Fall Med Trade Meeting there was significant discussion about providers that are receiving Cert Audits requesting additional documentation which is not published in LCD



EDUCATION



RESPIRATORY



REHAB



DME



DOCUMENTATION



ENTERAL/IV



OTHER



ATTACHMENT

or PA, such as a request of the provider to produce progress notes from the physician with specific notation of the patient's need or use of oxygen. Not all physicians document oxygen specifically in their progress notes. Providers are then receiving refund requests even though they have been able to show that the patient was seen by the physician. The Medical Director agreed during the Med Trade Meeting to follow up on this concern and respond. What is the status of this issue? (Questions 4 -10 were from Region D DAC as approved by TLC)

Answer: Medicare requires that payment for each claim be justified. The Medicare statutes allow the contractor to request whatever information is necessary to make a reasonable and necessary determination and substantiate payment. While contractors have traditionally focused reviews on whether coverage criteria were met for the initial DOS, it is clearly within the statutory authority of the contractor to determine that medical necessity continues to exist for claims submitted after that initial DOS.

- Respiratory providers understand the need to provide maintenance of equipment as necessary. The 11/5 communication states that the maintenance must be completed in the first six months (July). If the provider was not able to complete maintenance in the first month and completed it a month or two later for example, can they then bill for M & S once the M & S has been completed?

Answer: Yes, the supplier can bill Medicare for M&S on the date it is actually performed.

- Providers have received a significant increase in the number of Cert Audits. Some of these audit requests are for additional documentation for audits that were completed more than a year ago. What is the expectation of CMS regarding the volume and frequency of these audits in 2010? Should the providers expect to see the same volume in 2010 as experienced in 2009 or should the providers expect less or more in 2010?

Answer: The following answer is provided by CMS.

CERT reviews are associated with a one-year report period and once that period is over claims are not re-reviewed even if additional documentation is received. As always, I would be happy to investigate issues with specific claims if the provider or contractor provide the CERT Identification (CID) number.

During the 2009 report period CMS implemented changes to the CERT review criteria based on recommendations from the Office of Inspector General. In many cases this meant that CERT had to request additional documentation and re-review some claims that had been previously reviewed – possibly up to a year earlier. This is not typical; normally providers/suppliers can expect CERT to complete review of claims within a month or two of documentation submission. The process is prolonged if complete medical record documentation is not submitted and the CERT contractor has to request additional documentation.

We have not changed the sample size for the 2010 report period. The sample was set to comply with Improper Payment Information Act (IPIA) precision requirements and likely will remain fairly consistent.

- Providers are not receiving feedback from some of the audits for up to a year or a year and a half after the provider responded to a previous audit request. This makes it difficult for the provider to enact timely changes to their processing to minimize future errors. What can providers expect in 2010 regarding turnaround time for audit results?

Answer: See Question 6.

- This question is directed to the 1-800-Medicare Customer Service. They are advising patients “oxygen is a covered benefit” without asking any questions of the beneficiary. The issue is regarding providers in high altitude locations where oxygen is NOT covered (Medicare denies the claims) when patients who are not in a “chronic stable state”. The Medicare beneficiary



EDUCATION



RESPIRATORY



REHAB



DME



DOCUMENTATION



ENTERAL/IV



OTHER



ATTACHMENT

travels to a high altitude location and ends up in the hospital. The diagnosis is either Acute Mountain Sickness or High Altitude Pulmonary Edema. The oxygen testing is performed in the Emergency Room and the patient is NOT in a "chronic stable state." The patient may have COPD, but the testing is not performed as required for medical necessity by Medicare. The beneficiary calls the 800-Medicare number and is told "Yes, oxygen is covered" and yet the provider knows that it is not a covered item.

- a. Can CIGNA assist in educating the Customer Service staff at 1.800.Medicare to give a more appropriate answer?

Answer: CIGNA Government Services will forward this concern to CMS.

- b. Does Medicare consider it "routine" to give every Medicare patient an ABN for oxygen supplies when they travel to but do not reside in a high altitude location?

Answer: Issuing an ABN for this reason would not be considered "routine."

Rehab

1. Many power wheelchair suppliers have received pre-payment or post payment claim denials based on insufficient medical need being established for the PMD. One of the primary reasons given is a lack of quantitative strength, range of motion and/or endurance measurements being provided or that the strength and/or range of motion measurements do not support the physician's statement that the patient is unable to self-propel. (Julie Piriano, jpiriano@pridemobility.com)

- a. What level of strength, on a manual muscle test or other form of objective measure, has been deemed as appropriate to perform the repetitive motion necessary to self-propel a manual wheelchair by the medical review team as there is no evidence of a correlation in the literature or research?
- b. What shoulder, elbow, wrist and/or finger ROM limitations has been deemed to be insufficient to self-propel as there is no direct correlation clearly documented in the literature or research data.
- c. What is the best way to educate a physician with regard to quantitative measurement of endurance related to self-propulsion of a manual wheelchair?

Answer: As noted in the LCD and educational materials on PMD coverage and documentation criteria, review staff are looking for objective evidence describing the mobility limitation. Below is taken from the physician education article.

Physical examination that is relevant to mobility needs

- Weight and height
- Cardiopulmonary examination
- Musculoskeletal examination
- Arm and leg strength and range of motion
- Neurological examination
- Gait
- Balance and coordination

The evaluation should be tailored to the individual patient's conditions. The history should paint a picture of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.



EDUCATION



RESPIRATORY



REHAB



DME



DOCUMENTATION



ENTERAL/IV



OTHER



ATTACHMENT

2. If you have a neurological client (i.e ALS) that may not need a tilt/recline, etc.... at the time but does need a power wc base would you downcode the PMD to a Group 2? (Claudia Amortegui, claudia@orionreimbursement.net)

Answer: No. In all likelihood the patient with ALS would qualify for a Group 3 no power option power wheelchair. The tilt/recline would be denied if there was no medical necessity at the time the wheelchair base was dispensed. Medicare does not pay for "future need" items.

3. An ADMC approval (dated October 29) for a K9 wc was received from Region B, however it specifically stated that it was approved but would be paid at the K5 allowable. This should not be as K9 is an individually priced code and not every K9 is an ultra-lightweight (and/or titanium) wc. (Claudia Amortegui, claudia@orionreimbursement.net)

Answer: Jurisdiction C does not downcode from K9 to K5.

DME

1. Is there any update to the draft policy of E0217? (Questions 1-4 Laura Willard, Laura.Williard@advhomecare.org)

Answer: Comments are still being reviewed.

2. Has there been any further discussion to add the patients name to the IVR for information on recoupments. It currently only gives Medicare ID #.

Answer: CGS is looking into this as a future IVR enhancement. At this time, CGS does not have text-to-speech ability on its IVR, which means that the only way to give the patient's name on the IVR would be to read it letter for letter. We are exploring this possibility.

3. Has there been any further discussion on how to automate the C0176 denials to allow for claims to go automatically through without extending the CMN when payments have been recouped?

Answer: There has been no further discussion. There are multiple reasons for which C0176 is received. Some of these reasons being break in medical need, replacement equipment, and discontinued equipment. If your denial was based on one of the reasons listed above, the claim can be resubmitted with the information included in the narrative section.

4. For diabetic patients receiving supplies greater than the utilization guidelines, will a copy of the patient log in the physician's record suffice as documentation of testing?

Answer: The answer depends on whether the BGM claims for this beneficiary are for the first time or on an ongoing basis. For the establishment of medical need for this beneficiary, the supplier will need to present actual medical records indicating: (1) the beneficiary meets basic coverage criteria for BGM supplies, (2) the supplier correctly billed with either the KX or KS modifier, and (3) the treatment rationale for ordering a frequency of testing above the normal policy allowance. Once medical necessity is established, an order plus a current testing log as defined by policy would be sufficient to justify payment.

Options are still being researched on this issue. Nancy Kinsella is coordination with Wilma Johnson to research the process on creating a new modifier. We will follow up on this issue.

Documentation

1. Can we get an update on electronic records: what will the required documentation that is associated with accepting an electronic signature? Some of the records just appear to be a computer generated signature. It is tough to determine if the signatures are certified or a scan. (Laraine Forry, forrylm@lmfconsulting.com)



Answer: CGS follows the existing rules outlined in the CMS Internet-Only Manual, Pub. 100-08, Program Integrity Manual, Chapter 3, Section 3.4.1.1B for legible identifiers. CMS has not published separate guidance on electronic signatures.

- There is some confusion over the amount of medical necessity and follow up documentation required for Diabetic shoes. Could you give some specific guidance on this issue?

Answer: Please provide specific examples from policy.

Enteral/IV

- In reference to what qualifies for an enteral pump, is the risk of aspiration sufficient by itself, or must there be documented episodes of aspiration during gravity feeds for an enteral pump to be covered? (Questions 1-4, Kimberlie Rogers-Bowers, Kimberlie.Rogers-Bowers@apria.com)

Answer: Risk of aspiration is sufficient; however, the risk factor must be clearly identified in the documentation.

- We understand that a naso-gastric tube (ng tube) by itself will not justify the need for an enteral pump. Will a naso-jejunosotomy tube (nj tube) justify the use of an enteral pump in the absence of any other criteria?

Answer: The policy allows coverage for a pump with a gastrostomy or jejunostomy (whether percutaneous or nasal) tube as long as the coverage and benefit category requirements are met.

- The external infusion pump LCD states that A4222 (supplies per cassette/bag) or K0552 (supplies, syringe type cartridge) are covered during the period of covered use of an infusion pump. And in the Policy Article it states: K0552 describes a syringe-type reservoir that is used with the external insulin pump (E0784), the K0455 pump to administer epoprostenol/treprostinil, or E0779 pump to administer subcutaneous immune globulin.

Some syringe type pumps have been coded by PDAC (or previously by the SADMERC) as E0781 (e.g., Bard and Graesby pumps). The only option for billing the syringe reservoir/supplies for these pumps is K0552. Is K0552 a valid code for billing supplies for an E0781, syringe-type pump?

Answer: The requestor should address their question to the PDAC.

- The following appears in the enteral nutrition policy: If a pump (B9000-B9002) is ordered, there must be documentation in the patient's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunosotomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

My question is about your use of the term "gastrostomy/jejunosotomy". Does that mean a gastrostomy or a jejunostomy tube?

Answer: Yes

Or, does it mean the gastrostomy/jejunosotomy tube combination product (a g tube with a j tube inside of it)?

Answer: No, see above.

If a patient has a simple gastrostomy tube, would that justify the use of an enteral pump?

Answer: Yes, as long as the basic coverage and benefit category requirements are met.



5. Several providers are reporting incorrect payments generated by CGS, specifically for administration kits for non-covered drugs. Please review the following ICNs: (Pamela Dentino-Olson, Pamela.Olson@Walgreens.com)
- a. 09308793445000
 - b. 09338746695000
 - c. 09338746693000

Answer: These kits were paid in error. The processing instructions will be reviewed. Supplier should include a complete description when billing miscellaneous codes. These claims were billed with what appears to be an NDC number in the narrative.

Other

1. Please confirm that CMS has designated pharmacists as qualified providers of the TSD? (Questions 1-4, John Shero, jshero@regalmedical.com.)

Answer: CMS has not designated any specific providers as “qualified providers” of therapeutic shoes.

2. Is anyone aware of plans that the PDAC might have to revive the diabetic shoe review project that Dr. Edwards started at SADMERC, and that PFA was participating actively in?

Answer: CIGNA Government Services is unaware of any current or future review policies from the PDAC.

3. Are they anticipating any additional delays in PECOS implementation and, realistically, what is the future of PECOS?

We are still awaiting further instruction from CMS. All information received thus far from CMS is that PECOS will be implemented on April 4, 2010.

Attachment

Based on the information I have researched and reviewed (provided to you below); I think it is clear that CMS CERT, DME MAC Medical Review, BIU and etc.; have the right to request medical records to justify the medical need for the items provided; however they do not have the right to impose specific time frames for physician evaluation and follow-up evaluations; unless this requirement is specified in the equipment LCD such as is the case for Oxygen and date last seen requirements (30 days prior to initial, 90 days prior to recertification) and for PAP/RAD devices for the face to face evaluation prior to sleep study and re-evaluation Face to Face exam after set-up. Suppliers must obtain the physician medical records as requested; however if CERT denies based on the lack of an assessment for Nebulizer medications 12 months prior to the date of service and/or 6 months after the date of service; this is not a requirement in the Nebulizer LCD nor the PIM.

Supplier's cannot control and should not be held accountable for what is/is not documented in the physician's medical chart about a patient referred to them for DMEPOS items.



EDUCATION



RESPIRATORY



REHAB



DME



DOCUMENTATION



ENTERAL/IV



OTHER



ATTACHMENT

LCD Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. **For the items addressed in this medical policy, the criteria for “reasonable and necessary” is defined by the following indications and limitations of coverage and/or medical necessity.**

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

A small volume nebulizer (A7003, A7004, A7005), related compressor (E0570, E0571), and FDA-approved inhalation solutions of the drugs listed below are covered when:

- a. It is medically necessary to administer albuterol (J7611, J7613), budesonide (J7626), cromolyn (J7631), ipratropium (J7644), levalbuterol (J7612, J7614), or metaproterenol (J7669) for the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9); or

LCD Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider”. It is expected that the patient’s medical records will reflect the need for the care provided. The patient’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. **This documentation must be available upon request.**

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container. Examples of (a) would be: albuterol 0.083% 3 ml; or albuterol 0.5% 20 ml; or cromolyn 20 mg/2 ml. An example of (b) is: albuterol 1.25 mg in 3 ml saline. For compounded inhalation solutions, the order must include the following statement prior to signature by the physician: compounded inhalation solution – not FDA-approved. Administration instructions must specify the amount of solution and frequency of use. Examples would be: 3 ml qid and prn - max 6 doses/24 hr.; or one ampule q 4 hr prn; or 0.5 ml diluted with saline to 3.0 ml tid and prn. A new order is required if there is a change in the type of solution dispensed or the administration instructions. For all inhalation drugs, a new order is required at least every 12 months even if the prescription has not changed.

An ICD-9 code describing the condition which necessitates nebulizer therapy must be included on each claim for equipment, accessories, and/or drugs.

Below are Excerpts from the Program Integrity Manual Chapter 5 and Chapter 3:

5.7 – Documentation in the Patient’s Medical Record

(Rev. 242; Issued: 02-22-08; Effective/Implementation Dates: 03-01-08)

For any DMEPOS item to be covered by Medicare, the patient’s medical record must contain sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient’s record. However, neither a physician’s order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the



EDUCATION



RESPIRATORY



REHAB



DME



DOCUMENTATION



ENTERAL/IV



OTHER



ATTACHMENT

answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

See PIM, chapter 3, section 3.4.1.1, for additional instructions regarding review of documentation during pre- and post-payment review.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other health care professionals.

The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs, DME PSCs, or ZPICs. However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases. If the DME, DME PSCs, or ZPICs do not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

3.4.1 - Determinations Made During Prepayment and Postpayment MR (Rev. 71, 04-09-04)

When contractors review claims, either on a prepayment or postpayment basis, they may make any or all of the determinations listed below.

Contractors must be able to differentiate the type of determination made to ensure that limitations on liability determinations are made when appropriate.

When MR staff are reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination. However, when MR staff are performing BI-directed review, their focus may be different (e.g., looking for possible falsification, etc.)

A. Coverage Determinations

A claim may be covered, in full or in part, by a contractor if it meets all the conditions listed in PIM [Chapter 13, Section 13.4.1](#)

B. Limitation of Liability Determinations

In accordance with [§1879 of the Act](#), contractors first consider coverage determinations based on the absence of a benefit category or based on statutory exclusion. If both these conditions are met, [the next consideration should be whether the service was reasonable and necessary](#). [Section 1862\(a\)\(1\) of the Act is the authority for denial because a service is not reasonable and necessary](#). When a claim is denied, in full or in part, because an item or service is not reasonable and necessary, contractors make and document [§§1879, 1870, and 1842\(l\)](#) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal. Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary. See PIM Exhibits 14 - 14.3 for further details.

